SHOPS PLUS

Assessment of the Ghar Ghar Maa Swaasthya (GGMS) Project

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About SHOPS Plus: Sustaining Health Outcomes through the Private Sector (SHOPS) Plus is USAID's flagship initiative in private sector health. The project seeks to harness the full potential of the private sector and catalyze public-private engagement to improve health outcomes in family planning, HIV/AIDS, maternal and child health, and other health areas. SHOPS Plus supports the achievement of US government priorities, including preventing child and maternal deaths, an AIDS-free generation, and supporting the goals of FP2020. The project improves the equity and quality of the total health system, accelerating progress toward universal health coverage.

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Assessment of the GGMS Project

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Acronyms

AR	Annual Report
BCC	Behavior Change Communication
CBO	Community-Based Organization
CCA	Community Change Agent
COAG	Cooperative Agreement
CPR	Contraceptive Prevalence Rate
CRS	Nepal CRS Company
CYP	Couple Year of Protection
ECP	Emergency Contraception Pill
ERP	Enterprise Resource Planning (known as the “NAV” by CRS)
FP	Family Planning
GGMS	Ghar Ghar Maa Swaasthya
GoN	Government of Nepal
IC	Injectable Contraceptive
INGO	International Non-Governmental Organization
IPC	Interpersonal Communications
IR	Intermediate Result
IUD	Intrauterine Device
KAP	Knowledge, Attitudes, Practices
LQAS	Lot Quality Assurance Sampling
MCH	Maternal and Child Health
MEL	Monitoring, Evaluation and Learning (Plan)
MoHP	Ministry of Health and Population
mCPR	Modern Contraceptive Prevalence Rate
NCDA	Nepal Chemists and Druggist Association
NDHS	Nepal Demographic and Health Survey
OCP	Oral Contraceptive Pill
ORS	Oral Rehydration Salts
PD	Program Description
PLSA	USAID/Nepal Health Private Sector Landscape Assessment
PMP	Performance Monitoring Plan
PPP	Public-Private Partnership
QAO	Quality Assurance Officer
RAI	Remote Area Initiative
RH	Reproductive Health
SBCC	Social and Behavior Change Communication
SMO	Social Marketing Organization
SMODAT	Social Marketing Organization Development Assessment Tool
SWAp	Sector-Wide Approach
TA	Technical Assistance
TAP	Technical Assistance Partner
TMA	Total Market Approach
TSV	Technical Support Visit
USAID	United States Agency for International Development
WRA	Women of Reproductive Age

Acknowledgments

The Assessment Team would like to thank USAID/Nepal Health Office for the opportunity to conduct this assessment of the Ghar Ghar Maa Swaasthya project. The Team is grateful for the assistance of the many government officials and stakeholders who shared their perspectives on GGMS and CRS. We also appreciate the time and insights shared by the CRS staff. We hope that this report is useful to USAID/Nepal, CRS, and stakeholders as they design and implement future interventions that promote the health and quality of life of the people of Nepal.

Executive Summary

Assessment Scope and Methodology

The USAID/Nepal Health Office requested that the Sustaining Health Outcomes through the Private Sector (SHOPS) Plus project assess the Ghar Ghar Maa Swaasthya (GGMS) project, a cooperative agreement (COAG) funded by USAID and implemented by the Nepal CRS Company (CRS) since May 2010. USAID and SHOPS Plus agreed that the assessment would cover the following areas:

- The performance of CRS in implementing the GGMS project;
- The impact of GGMS and CRS activities in the private health sector; and
- Future opportunities for developing the private health sector in general and integrating social marketing in a private health sector strategy.

SHOPS Plus engaged an Assessment Team (the "Team") comprised of two independent consultants and one private sector specialist from Abt Associates to perform the assessment. SHOPS Plus provided a list of questions to be answered under each area of the assessment. See Annex 1 for the scope of work and assessment questions.

The assessment findings are intended to support USAID in measuring GGMS performance and in designing future investments in social marketing and increasing private sector engagement for health, as well as to assist CRS in improving its performance.

The Team used a mixed methods approach including document review, key informant interviews, and site visits. CRS provided much of the information for the first area covered by the assessment. Performance against the indicators in the performance monitoring plan (PMP), results framework (RF) and monitoring, evaluation, and learning (MEL) plan provided the foundation for the first part of the assessment. The second two areas covered by the assessment relied more on interviews outside of CRS, site visits, and a review of secondary data.

The Team reviewed a large amount of data and documents, and conducted interviews with many stakeholders and CRS staff. Time constraints did not allow for verification of data and reports as might have been possible for a full project evaluation. While the Nepal Demographic and Health Survey (NDHS) provided valuable data for understanding contraceptive use, the lack of more recent nationally-representative data limited the ability to assess GGMS impact over the last two years.

Project Background

Since its inception in 1976, CRS has been the key social marketing partner to the Ministry of Health and Population (MoHP) and the leading non-state supplier of family planning (FP) products in Nepal. CRS products are present in all 77 districts of Nepal, and reach more than 7,000 pharmacies throughout the country. CRS has benefited from continuous support from USAID for over 40 years both through direct funding to CRS and through sub-agreements with international non-governmental organizations (NGOs).

In May 2010, CRS received a five-year COAG from USAID/Nepal for the GGMS Project. GGMS was designed to leverage CRS's national capacity for promotion and distribution of health products, especially for FP, to contribute to the goal of improving the health of disadvantaged populations in Nepal. Increasing the sustainability and efficiency of CRS are also a focus of GGMS. FHI 360 was selected by USAID as the technical assistance partner (TAP) for this phase to support CRS's institutional development. In mid-2015, USAID extended GGMS for an additional five years to continue work on improving access to and use of key health products, but with an additional focus on improving CRS's institutional strength and independence. USAID selected Abt Associates, through the SHOPS Plus project, as the TAP for this phase.

Findings

Project achievements

CRS is achieving key GGMS objectives but higher-level goals for health impact and institutional development will likely fall short of expectations:

- CRS is likely to meet the target of 4.0 million couple years of protection (CYP) generated through the sale of contraceptives, which continues to account for a significant share of Nepal's mCPR. **Increases in CRS's CYP did not lead to increases in mCPR between 2006 and 2016 and may not be driving increases now.**
- CRS is achieving a higher average cost recovery rate across its product portfolio which was largely achieved through price increases. **Achieving the target of 58 percent average cost recovery will be challenging and would still leave CRS a long way from sustaining itself through sales revenue. Further price increases for some brands appear to pose a low risk to contraceptive use but other CRS brands and initiatives likely require additional donor support to have an impact with harder-to-reach populations.**
- CRS is improving as an organization both functionally and technically as shown by its increasing score on the Social Marketing Organizational Development Assessment Tool (SMODAT) reflecting a new enterprise resource planning (ERP) system, stronger HR systems, and more use of research, among other areas. **CRS has yet to attract new donors or demonstrate versatile technical capacity. Organizational improvements may be fragile without a strong organizational commitment to change. Demonstrating behavior change in the Remote Area Initiative (RAI) would be a strong positive indicator of increased capability.**

Impact on the private sector

GGMS is likely having a negative impact on the commercial health product market and a modest positive impact on service delivery in the private sector:

- There are signs of "crowding out" of the commercial sector. There have been no new brand entrants of meaningful scale during GGMS in the market for contraceptives (other

than condoms) and CRS continues to dominate the commercial market for oral contraceptives (OCP) and injectables (>90% share).

- The overall contraceptive market does not appear to have grown in volume but there have been modest gains in value (revenue generated) driven both by an increase in the market share of commercial condoms and CRS's own price increases.
- The Sangini network has expanded and CRS has trained more private sector providers but third-party assessments indicate that the training curriculum needs further development. CRS lacks resources to maintain quality across such a large number of service points, and mystery client surveys suggest that network quality is lower than technical support visits (TSV) from CRS Quality Assurance Officers (QAO) indicate.

GGMS project design

Some of the challenges in achieving higher goals and the negative effect on the commercial sector relate to the project design:

- GGMS was designed with a focus on CRS's sales and CYP without deliberate attempts to engage commercial players through a total market approach (TMA).
- Behavior change communication (BCC) including advertising and promotion is underfunded relative to the size of the population GGMS is trying to serve.
- Striving to increase average cost recovery rates while also reaching hill and mountain districts and increasing quality in Sangini is challenging. These initiatives require resources and would drive up any organization's costs.
- Emphasis on increasing cost recovery, especially in the Phase 1 program description, tends to overshadow the need to spend more on quality assurance and intensive behavior change interventions.

Current engagement of the private sector

Recent statistics reveal the private sector in Nepal has more hospital beds than the public sector and is an overwhelming source for caregivers seeking care for their sick child. The private sector also provides more than 30 percent of all modern contraceptive methods in the country and 60 percent of OCPs. Given the private sector's importance to health product and service provision, it is important to identify challenges they face, including:

- **Dialogue**: Public-private dialogue is currently piecemeal and the private for-profit sector is routinely excluded. There are many overlapping committees at the MoHP and DDA, of which only a handful meet regularly. While no private sector umbrella organization exists, there are cadre-specific public-private organizations that advocate for their constituencies such as the National Medical Association. International NGOs tend to be included in

health dialogue convenings but local actors are excluded. Stronger and more inclusive dialogue between the public and private sectors is needed.

- **Public Private Partnership (PPP)**: While health PPPs exist, particularly for provision of health services and for medical colleges, they are currently ad hoc with no guidelines to help private sector actors navigate the process. Most PPPs are with NGOs or large private hospitals.
- **Regulation**: Regulation of the private sector is in transition. With the anticipated enactment of the Public Health Policy and PPP Guidelines, the private sector's role will be clearer. Private sector authorization and quality assurance is overseen by several government agencies, which can be confusing for the private sector to navigate. Stakeholders interviewed for this assessment spoke of variable quality in the private sector, particularly for unauthorized facilities and the need to clarify and disseminate private sector requirements.
- **Health financing**: The fledgling social health insurance program has made great strides since it launched three years ago, but its reach is still limited. Over 135 private health facilities are currently part of the program but there is room for much larger private sector participation.
- **TMA**: While stakeholders identify challenges that could potentially be overcome through cross-sectoral collaboration stewarded by the MoHP. TMA is not yet part of the public-private dialogue, TMA principles are not widely understood, and data to inform a TMA is collected piecemeal.

Recommendations

Design

Apply TMA principles. TMA-inspired interventions would help the Government of Nepal (GoN) create a more enabling environment and bring together non-state actors (NGO and commercial) to work collaboratively on supply and demand barriers facing multiple population segments. It would also focus attention on the higher goal of increasing mCPR rather than each organization's CYP. Key TMA actions are outlined below under Key Interventions and in Section 5. First steps should include developing a vision for the contraceptive market that includes appropriate roles for the public, non-profit subsidized, and commercial sectors, as well as strengthening the GoN's capacity for market stewardship.

Think more broadly about the role of social marketing. Rather than focusing on branded socially marketed products and their average cost recovery, invest in programs that bring social marketing skills to the challenges of changing consumer and provider behaviors to grow product categories and increase product use, including in harder-to-reach areas. This could include separating self-sustaining social enterprise activities from interventions that require sustained donor or government funding.

Key Interventions

Overarching investments in private sector engagement

- **Invest in market stewardship capacity of the GoN** to build partnerships and work toward a TMA. A technically strong and empowered stewardship team within the GoN, including the MoHP and decentralized government units, is crucial to move the vision forward and to lead cross-sectoral collaboration.
- **Support foundational steps to improve the organization of the private sector**, including support for the development of public-private dialogue platforms at the national and local levels and for convening of private sector stakeholders to identify common goals and determine whether a private sector association is necessary.
- **Support GoN efforts at improving the quality of products and services through regulation**, including finalizing and disseminating regulations to private health facilities, expanding private sector mapping beyond SSBH's current focus, and providing technical assistance to non-authorized facilities to help them become authorized and improve their quality of care. An autonomous accreditation body for quality assurance is also needed.
- **Promote greater private sector engagement by the public sector** by supporting the identification and rationalization of health committees at each government agency and ensuring all private sector stakeholders are included. Support is also needed to launch provincial and municipal level dialogue platforms and tie these efforts in with PPP training and dissemination the pending partnership guidelines.
- **Invest more in BCC**. Multi-channel BCC and promotional campaigns for product categories, rather than specific brands, are public goods that benefit all sectors if interventions are well funded enough to sustain a high level of exposure for target audiences. There are a range of partners in Nepal capable of playing key roles, including CRS. Support should go to those best placed to serve specific populations and geographic areas.

Product distribution and service delivery networks

- **CRS should consider transitioning to a social enterprise model for D'zire, Panther, Nilocon White and e-CON in urban and peri-urban areas**. These products are likely to be covering all of their costs and could likely serve urban and peri-urban markets without further subsidy. A separate, self-sustaining unit could manage this portfolio, as well as other self-sustaining products that could be added to the portfolio.
- **Narrowly target support for condoms and OCPs in harder-to-reach areas**. Continued untargeted subsidies for Dhaal and Sunaulo Gulaf are likely to benefit many who could

pay more. A more targeted approach to offering subsidized condoms and OCPs could be designed to meet the needs of population segments not reached through a social enterprise model. This support could include, or be complementary to, efforts to strengthen GoN systems that deliver free condoms and OCPs through the public sector.

- **Continue injectable supply through CRS in the medium term**. Sangini branded injectables serve a substantial number of women, and no other private sector or NGO actor is currently well placed to make a contribution at scale. Over the longer-term, a PPP to ensure supply from multiple entities accompanied by an appropriate training and certification program should be explored.
- **Invest in service delivery networks**. To the extent that US government rules allow working with organizations already managing service delivery networks in Nepal (FPAN, MSI, PSI) further investment in provider training, provider behavior change, and quality assurance would provide a platform for offering the full range of contraceptive products and services. Support could include the Sangini network, with a goal of increasing quality within a manageable number of service points (perhaps under a more limited accreditation model). Donors can also support reactivating a dormant dialogue platform with FPAN, MSI, PSI, and CRS participation. Refer to Section 5 for further discussion.

1. Assessment Scope and Methodology

The USAID/Nepal Health Office requested that SHOPS Plus perform an assessment of the Ghar Ghar Maa Swaasthya (GGMS) project, a cooperative agreement (COAG) funded by USAID since May 2010. USAID and SHOPS Plus agreed that the assessment would cover the following areas:

- The performance of CRS in implementing the GGMS project
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The assessment findings are intended to support USAID in measuring GGMS performance and in designing future investments in social marketing and increasing private sector engagement for health, and to assist CRS in improving its performance.

The Team used a mixed-methods approach including document review, key informant interviews and site visits.

Documents reviewed included the GGMS COAG, program description (PD) and modifications; the performance monitoring plan (PMP), results framework (RF), and monitoring, evaluation and learning (MEL) plan; annual workplans and annual reports (for CRS, FHI 360, and SHOPS Plus); sales and financial reports; project research and other publicly available research (e.g., the Nepal Demographic and Health Surveys (NDHS)); previous assessments and evaluations related to social marketing and private sector engagement in Nepal; and other relevant published and gray literature. See Annex 2 for a list of documents reviewed.

Key informants included CRS staff, SHOPS Plus staff, government representatives, private commercial sector actors including distributors, wholesalers, retailers, and providers, convening bodies, donors active in health and private sector engagement, and other international and local NGOs working in health areas related to GGMS's work. The Team also met with USAID/Nepal staff responsible for the project. See Annex 3 for a list of stakeholders interviewed.

Site visits included areas in and around Kathmandu and a CRS area office in Nepalgunj to view CRS activities and meet implementation partners on the ground. The visits included interviews with many private sector stakeholders in health.

CRS provided much of the information for the first area covered by the assessment; performance against the indicators in the PMP, RF and MEL plan provided the foundation for this part of the assessment. The second two areas covered by the assessment relied more on interviews outside of CRS, site visits, and a review of secondary data.

Limitations

The Team reviewed a large amount of data and documents, and conducted interviews with many stakeholders and CRS staff. Time constraints did not allow for independent verification of data and reports as might have been possible with a full project evaluation rather than an assessment. While the NDHS provided valuable data for understanding contraceptive use, the lack of more recent nationally-representative data limited the ability to assess GGMS impact over the last two years.

2. Project Background

Since its inception in 1976, Nepal CRS Company (CRS) has been the key social marketing partner to the MoHP and the leading non-state supplier of family planning (FP) products in Nepal. CRS products are present in all 75 districts of Nepal, and reach more than 7,000 pharmacies throughout the country. CRS also has an extensive network of drug shops and clinics – known as "Sangini" – in the 75 districts to support provision of injectable contraceptives. CRS's status as a market leader in short-acting FP methods is demonstrated by its market share. According to CRS, nearly 46 percent of Nepal's condom users use a CRS brand; 67 percent of oral contraceptive pill users use a CRS brand; and CRS supplies approximately 25 percent of Nepal's injectables.

CRS has benefited from continuous support from USAID for over 40 years both through direct funding and through sub-agreements with international NGOs. More recently, CRS has received funding from KfW to support commodity purchases and product distribution. CRS has benefited from a strong partnership with the MoHP and other government entities, several of whom hold seats on CRS's board, as well as partnerships with local associations.

Nepal has made considerable progress in improving the health status of its population over the past two decades. Particular strides have been made in FP and maternal and child health (MCH). Between 1996 and 2016, the maternal mortality rate declined from 539 to 239 deaths per 100,000 live births (NHSP-III draft, 2015). Nepal's total fertility rate declined from 4.6 in 1996 to 2.3 in 2016, while the percentage of married women using contraception increased from 28.5 to 52.6 over the same time period (NDHS 2016).

Despite this progress, gaps in access to priority health services remain, especially in the hard-to-reach areas of Nepal. Greater efforts are needed to empower women to make informed decisions regarding their own health and that of their family members. For example, there are many missed opportunities to provide counselling on contraception during post-abortion, post-partum, and child health visits. The NDHS 2016 found that only 13.3% of women received FP counseling during a post-partum visit. Rural women also need greater access to short-acting methods, including injectables and pills. FP promotion strategies must also address the needs of couples who are often separated due to seasonal migration for work. The NDHS 2016 also found that while 37% of children experiencing diarrhea in the two weeks preceding the survey received oral rehydration solutions (ORS), only 17.6 percent received zinc. The concentrated HIV epidemic is another health challenge in Nepal. In 2014, the HIV prevalence in Nepal was 0.2 percent among the general population but 2.0% among female sex workers. Sources estimate that between 0.4 percent and 2.0 percent of women of reproductive age in Nepal engage in sex work, demonstrating an ongoing need for HIV interventions targeting this key population.

In May 2010, CRS received a five-year COAG from USAID/Nepal for the GGMS Project. This five-year period is referred to as Phase 1 in the assessment. GGMS was designed to leverage CRS's national capacity for promotion and distribution of health products, especially for FP, to contribute to the goal of improving the health of disadvantaged populations in Nepal.

In Phase 1, CRS continued many of its long-running strategies focusing largely on increasing access through the sale of subsidized products in traditional outlets (e.g. pharmacies) and non-traditional outlets (e.g. small shops). CRS continued to make injectables available through the Sangini network. Although national distribution is supported under GGMS, CRS was asked to intensify distribution and promotion in 49 hill and mountain districts to better serve target groups

with limited access to contraceptives. To reach these areas, CRS sought to create new partnerships with community-based organizations (CBOs), youth clubs, and other NGOs, while also expanding the Sangini network. CRS also identified new distributors serving these areas and adjusted its performance-based incentives for staff and distributors to reach under-served areas.

CRS continued to address demand side barriers in this phase through a range of behavior change interventions. Under GGMS, CRS introduced the Remote Area Initiative (RAI) which seeks to intensify exposure to behavior change messages through a range of channels including community change agents (CCA) trained and supervised directly by CRS.

Increasing the sustainability and efficiency of CRS were also a focus in Phase 1. This included plans to: increase product prices to increase revenue; introduce new profit-making products; build and integrate new processes to improve cost-efficiency; and establish relationships with new international and national donors. FHI 360 was selected by USAID as the technical assistance partner (TAP) for this phase to support CRS's institutional development.

In mid-2015, USAID extended GGMS for an additional five years to continue work on improving access to and use of key health products, but with an additional focus on improving CRS's institutional strength and independence. This period, which is ongoing through April 30, 2020, is referred to as Phase 2 in the assessment.

The Phase 2 approach remained similar to Phase 1: increasing demand through a mix of branded and generic messages delivered through multiple communications channels; increasing access with an emphasis on hot zones and harder-to-reach hill and mountain areas; creating an efficient and effective social marketing platform; and strengthening organizational policies and procedures. In line with Phase 1 objectives, increasing the average cost recovery for the product portfolio was identified as a critical sustainability strategy. A second round of the RAI was designed in new districts based on lessons learned from the first round.

USAID selected SHOPS Plus as the TAP for this phase. SHOPS Plus had previously conducted an assessment of CRS, which identified areas of focus for institutional strengthening. These areas included: realigning CRS's sales, marketing, and behavior change approaches to international best practice; using entrepreneurial approaches to increase product availability in high-risk venues; increasing the operational efficiency of CRS's platform and revising pricing strategies; strengthening organizational procedures and skills to enable CRS to respond to changing public health needs and opportunities.

3. Progress Toward Achieving GGMS Objectives

The GGMS project's objectives are defined in the program descriptions (PD) and results frameworks (RF) included in the COAG, as well as in the Phase 1 performance monitoring plan (PMP) and the Phase 2 monitoring, evaluation, and learning (MEL) plan. These include a strategic objective (SO) and several intermediate results (IR) and sub-IRs.

The Team noted significant differences at the sub-IR level between the Phase 2 RF included in the COAG (and subsequent modifications) and the MEL plan.[1] Since the RF includes a more robust set of indicators for institutional development, which form a stronger basis for assessing progress, the report's findings refer to both sets of sub-IRs and indicators.

GGMS results fall broadly into two categories: 1) programmatic results related to product distribution, service delivery, and behavior change; and 2) institutional development results related to CRS's evolution as an organization, including cost recovery objectives. The assessment groups findings under those two categories. For each section, the assessment addresses achievements and progress against the objectives, followed by a discussion of factors that influenced performance and considerations for future programs.

Progress Toward Programmatic Objectives

Progress toward the strategic objective

The GGMS project's strategic objective is to change behaviors related to reproductive health (RH) and MCH to contribute to the goal of improving the health of disadvantaged populations in Nepal. It is too early to tell whether GGMS will achieve this strategic objective by the end of the project. Baseline data for behavioral indicators was not available until mid-2018 and end-line data will not be collected until 2020. The MEL plan does not include targets for the level of behavior change. During Phase 1, however, baseline and end-line knowledge, attitudes, and practices (KAP) surveys indicated that mCPR and ORS use declined in areas covered by GGMS (Maternal and Child Health, Knowledge, Attitudes and Practices Survey in 49 Hill and Mountain Districts: A Comparative Analysis: 2011-2015). While there was no end-line quantitative survey in a first round of the RAI, a qualitative assessment identified a number of programmatic weaknesses to be addressed to increase the likelihood of behavior change in the districts selected for the second round.

1 In the Team's view, the RF for GGMS Phase 2 (included in MOD 14) is more thorough in laying out a logical/causal set of institutional development indicators than the MEL plan. The MEL plan both condenses and reorganizes the indicators from the RF. For example, sub-IR 1.1 "CRS's capacity to implement evidence-based social marketing increased" would seem to be better placed under IR 3 "Increased sustainability of CRS" rather than under IR 1 "Increased demand for priority products." It is also not clear from the MEL plan how indicator 1.1.1 "Number of people reached through SBCC" addresses sub-IR 1.1 "CRS's capacity to implement evidence-based social marketing increased." The robust set of 11 indicators for CRS sustainability is also reduced to 4 indicators, two of which do not seem to relate directly to the IR (indicators 3.2.1 and 3.2.2 relating to Sangini quality, but included under the sub IR for Improved Organizational Capacity of CRS).

Table 1. Progress toward the strategic objective: increased use of GGMS-supported products HIV, FP and MCH services

Indicator	Progress
Percentage of married and/or cohabitating women aged 15-49 reporting current use of a modern FP method (GGMS districts)	In Phase 1, mCPR decreased from 45% to 39%[2] Phase 2 baseline (in RAI districts) is 39% (Shiras, Karki, and Bradley, 2018)
Percent of under-5 children with diarrhea treated by zinc and ORS	In Phase 1, ORS use declined from 42% to 37% for youngest child and from 47% to 46% for second youngest child[3] Phase 2 baseline is 26% for ORS and zinc together
Percentage of women receiving four or more antenatal care visits (RAI districts)	No data collected by the project in Phase 1 Phase 2 baseline is 71%
Percentage of women delivering in health facility (RAI districts)	No data collected by the project in Phase 1 Phase 2 baseline is 64%
Percent of households in target areas practicing correct use of recommended household water treatment technologies	Indicator included in the most recent RF in the latest MOD but not included in the MEL plan; no data collected by the project
Percent of target population who report practicing hand washing at six critical times	Indicator included in the most recent RF in the latest MOD but not included in the MEL plan; no data collected by the project

Progress toward programmatic IRs and Sub-IRs

CYPs

Generating CYPs through the sale of contraceptives in the private sector is a key programmatic indicator of success for GGMS. CYP targets are included under IR 1 in the Phase 1 PMP ("increased supply of selected commodities in hard to reach rural areas") and under IR 1 in the Phase 2 MEL plan ("increased demand for priority products and services").

CRS committed to generating 1.8 million CYP in Phase 1 and 2.2 million CYP in Phase 2.[4]According to CRS's reporting, GGMS is likely to achieve these CYP targets:

2 Page 103 of FHI KAP
3 Table 5.11 of FHI KAP
4 This would be 4.0 million CYP over the 10-year project, though the Phase 2 PD refers to a 4.3 million CYP target.

- CRS generated 1.86 million CYP in Phase 1 from sales in the period FY 2010/11 through FY 2014/15,
- CRS generated 1.4 million CYP in the first three years of Phase 2 (through July 2018). Continuing at that average annual CYP through the end of the project would be sufficient to achieve the five-year target.

Achievement of Phase 1 programmatic indicators

The indicators included in the Phase 1 PMP reflect the approach presented in the PD and summarized in the Project Background. Achievements generally met targets for key programmatic areas, though sales of some, non-CYP generating, products fell considerably short. The appropriateness of the indicators in capturing progress as well as the reasons for falling short in some areas are discussed at the end of Section 3.

Progress toward Phase 2 programmatic indicators

A number of the Phase 2 indicators still have end-line targets "to be determined" (TBD) per the approved MEL plan. To date, CRS has generally achieved annual targets for product sales and the reach of BCC activities. CRS has embraced the approach to measuring coverage through the percentage of enumeration areas that meet minimum standards, which is an improvement over the previous method of counting sales outlets opened. CRS is on track to meet the coverage standard in hot zones. The coverage standard for contraceptive availability has been challenging to set and is still being revised. Training targets for the Sangini network are also on track. TSVs report that quality standards are also being met, though the recent Mystery Client Survey suggests that TSVs are overestimating quality.

Table 2. Phase 1 achievements against programmatic sub-IRs

Sub IR	Indicator	Target	Achieved
1.1 Increased Availability of selected quality FP and MCH commodities in rural areas hard to reach area	Sales of Nava Jeevan (ORS)	14,950,000	☒ 14,458,245 (97%)
	Sales of PIYUSH (water chlorination)	537,249	☒ 393,255 (73%)
	Sales of Sutkeri Samagri (CDK)	854,714	☒ 217,777 (25%)
	Sales of Virex (chlorine disinfection powder)	636,615	☒ 87,353 (14%)
	New outlets (opened) in 16 mountain and 33 hill districts selling USAID subsidized condoms, supplied directly by CRS	4,560	☑ 7,144 (157%)
	Existing outlets in 16 mountain and 33 hill districts resupplied with USAID subsidized condoms, supplied directly by CRS	6,564	☒ 5,680 (87%) (in 14/15)
	Sangini service providers in 49 mountain and hill districts	900	☑ 1,141 (127%)
	Dialogue meetings held	180	Not reported in AR
	Baseline contextual assessments completed	26	Not reported in AR
	Collaborative plans submitted on time	13	Not reported in AR

Sub IR	Indicator	Target	Achieved
1.2 Improved systems for quality assurance and waste management	% of franchise outlets that meet minimum quality standards	65%	67%
	People trained in FP/RH with USG funds	1,900	☑ 3,852 (203%)
2.1 Increased availability of commercial condoms in traditional and non-traditional outlets of hot zones	% of condom-selling outlets in hot zones stocking commercial brand of condoms, disaggregated by brand	45%	ARs only include outlets opened
	Dialogue meetings held with commercial partners	108	Not reported in AR
2.2 Increased accessibility of subsidized social marketed condoms for FSWs	% of hot spots with at least one condom-selling outlet within 100 meters	70%	ARs only include outlets opened
	Dialogue meetings held with HIV Stakeholders	108	Not reported in AR
2.3 Increased availability of STI treatment products in traditional outlets	STI treatment kits (Cure) for male urethritis sold through selected traditional outlets along highway routes	73,000	☒ 11,193 (15%)
	People trained on STI treatment kits for male urethritis	No target	102 (not reported after 2010/11)
2.4 Percentage coverage of geographically defined hot zones with quality condoms and STI treatment products	% of hot zones with one condom-selling outlet per five hot spots	80%	ARs only include outlets opened
	% of hot zones with one STI treatment-selling outlet per five hot spots	70%	ARs only include outlets opened

Sub IR	Indicator	Target	Achieved
4.1 Enhanced awareness and positive attitude change concerning selected quality FP and MCH behaviors in rural, hard to reach areas	% of women of reproductive age who are currently using a modern method of contraception	No target	39%
	% of married persons who know where to get selected MCH commodities	No target	Not in KAP
	People reached with FP/RH messages	4,850	☑ 11,321 (233%)
	People reached with MCH messages	4,850	☑ 11,321 (233%)
4.2 Enhanced awareness and positive attitude change concerning selected HIV/AIDS prevention behaviors in urban hot zone areas	People reached with HIV prevention messages with USG funds, disaggregated by gender	11,470	☑ 32,743 (285%)

Sources: Sales data provided by CRS for period August 2010 through July 2015; FHI KAP; distribution surveys; annual reports (AR) cumulative or final year depending on indicator

Table 3. Summary of Phase 2 RF and MEL programmatic indicators, targets, and progress

Indicator	Target	Progress
Number of CRS-supported products sold (MEL and RF)	For 16/17 & 17/18 per MEL plan: Nilocon White: 2.3 m Sangini: 1.8 m Dhaal: 14.2 m Panther: 6.5 m D'zire: 2.8 m	☑ Nilocon White: 2.5 m ☑ Sangini: 1.9 m ☑ Dhaal: 14.4 m ☒ Panther: 6.1 m ☑ D'zire: 2.9 m
People reached through SBCC activities in RAI districts (MEL and PD)	455,000 (200,000 in the PD)	CRS reporting to USAID on MEL plan only shows 2016/17 which has a target of 110,000 and an actual of 110,954
% of geographic units (enumeration areas) in hot zones where condom availability meets minimum project standards (MEL and RF)	Baseline from is 58%. Target is 80%.	CRS has so far achieved 76% coverage standard against the minimum project standard of 80% in hot-zones. 4 of 6 supervision areas met the target of 80% (per 17/18 AR)
% of geographic units (enumeration areas) where availability of contraceptive methods meets minimum project standards (MEL and RF)	Baselines from 17/18 are low and the targets are TBD.	Not yet meeting target. Fair to re-evaluate the coverage targets here.
People trained in FP/RH with USG assistance (MEL)	300 for 16/17 – 17/18 180 for 18/19 TBD for 19/20	☑ 341 for 16/17 – 17/18

Indicator	Target	Progress
Number of new outlets opened in geographical units that are below the coverage standards (MEL and RF)	Hot Zones: 16/17 target = 790 Rural and feeder: 16/17 = 1,763	☑ Hot zones = 957 ☑ Rural and feeder = 2,075
New products launched (MEL and RF)	TBD	Working on sanitary napkins and ORS/zinc co-pack
% of Sangini service points that meet minimum standard of quality of care (MEL)	75%	70% up to 16/17 based on TSVs. But Mystery Client Survey would suggest this is considerably lower.
Sangini service points visited for TSV (MEL)	1,300 in last year	Averaged 730 first two years measured. (This represents a very low coverage of less than 25% of overall Sangini service points but 58% of points in GGMS districts.)
% of target groups who report intending to use priority products and services (RF)	No targets in the current MEL plan for these indicators which were new in Phase 2. KAP surveys should inform targets and document progress.	SHOPS Plus supported a “Reach and Recall” survey for D’zire condoms which showed that intention to use increased in CRS’s priority audiences.
% of target groups who report positive perceptions of CRS brands (RF)		The “Reach and Recall” survey showed that already strong positive perceptions of D’zire increased after the campaign.
% of target groups who report priority products and services are accessible and affordable (RF)		Data not available.

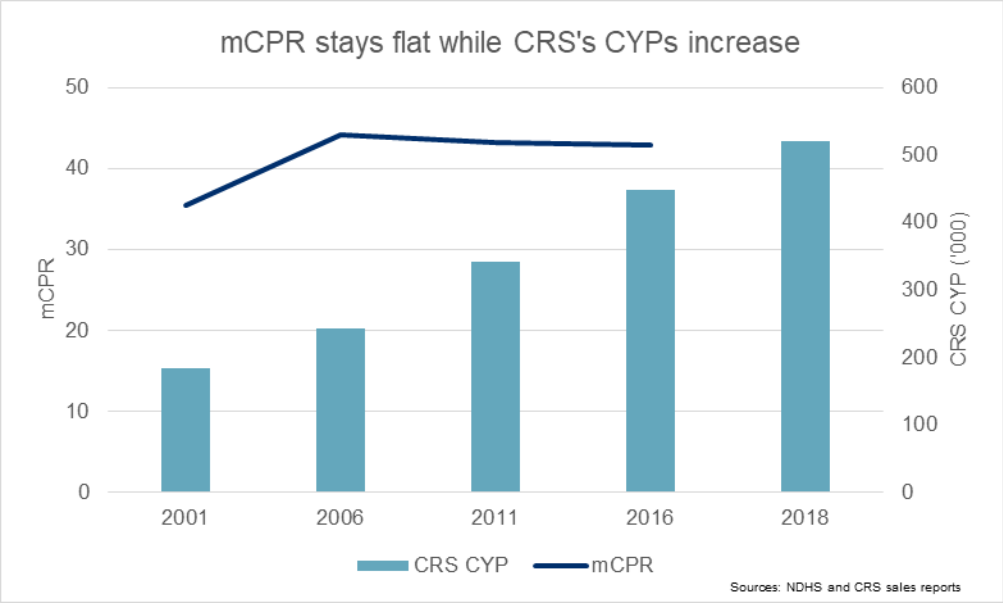
Indicator	Target	Progress
% of audience who recall hearing or seeing a specific CRS supported message (RF)		The “Reach and Recall” survey showed that 39% of respondents recalled an advertisement from a two-month multichannel campaign. The survey also showed that ever-use of D’zire increased This type of survey is best practice that CRS should repeat to demonstrate impact after campaigns and inform future campaigns.

Sources: Sales data provided by CRS for period August 2015 through July 2018; annual reports (AR), baseline surveys

Factors influencing performance and considerations for future projects (programmatic)

- CRS has been consistent in increasing CYP over the years. They have built and maintained strong relationships with distributors and wholesalers, who, in interviews, report trusting their relationship with CRS. CRS brands are well known to the trade and consumers. Sales have consistently risen in spite of modest price increases, suggesting that CRS could be more aggressive in managing prices.
- CRS's presence in the market is significant enough that increases in its CYP can drive increases in mCPR. However, a comparison of the NDHS and CRS sales data suggests this is not happening. CRS's CYP have increased substantially (more than the growth in women of reproductive age (WRA)) while mCPR has remained flat (see Figure 1). This would be possible if more women were switching to CRS from other contraceptive suppliers, but the NDHS actually shows that slightly more women are sourcing contraceptives from the public sector (a change from 69.0% to 69.5% between 2011 and 2016). Further analysis of the total market for contraceptives is critical to explore the relationship between a flat mCPR and CRS's increasing CYP. This will help understand market dynamics that can drive increases in mCPR. Setting targets within a total market context (e.g. measuring the contributions of government, social marketing and commercial) would also help focus on the larger goal of increasing mCPR.

Figure 1. Trends in mCPR and CRS's CYPs



- Funding for BCC, including branded promotion, to generate product demand is relatively low within GGMS. The most recent CRS audit shows spending of roughly $450,000 for advertising and promotion to reach a target population of WRA exceeding 7 million. This represented less than 25 percent of CRS's annual expenditure, and only $0.66 for every dollar spent on commodities and packaging. While there are no standard benchmarks for spending on BCC and promotion, many social marketing programs would have a higher spend per WRA and/or a higher ratio of communications versus commodities. An increase in resources for behavior change interventions would be consistent with findings elsewhere that demand-side barriers have grown in importance as product availability has continued to increase.
- The RAI program is well-intentioned and now has a better design in Round 2 based on SHOPS Plus's assessment of Round 1. However, the intensity of the SBCC activities is not likely to result in sufficient repeat exposure to deliver on the many behavior change results.
- The American College of Nurse-Midwives (ACNM) assessment identified a number of critical weaknesses in the Sangini network that are still in the process of being resolved. Until recently, there had been no QA manager, which resulted in very limited planning or oversight of CRS's QA process and supervision of Quality Assurance Officers (QAO). ACNM found that training for Sangini service providers lacks adequate focus on critical information and does not incorporate enough competency-based teaching and evaluation methodologies; as a result, providers are not adequately oriented to the issues related to quality of service. TA from SHOPS Plus is improving data collection and reporting tools. However, existing TSV processes require strengthening in a number of areas, most urgently in improving their capacity to influence provider behaviors. The ratio of QAOs to service points remains very low, which makes it nearly impossible to maintain enough contact to ensure inadequacies are addressed. The current scope of GGMS excludes TSVs outside GGMS districts, which further complicates quality assurance.
- CRS is transitioning to a greater focus on quality of coverage in defined geographic areas rather than simply on opening new outlets. This is likely to improve efficiency over time. To further drive efficiencies, more work could be done to overlay outlet coverage data with consumer perceptions of product availability to determine at what coverage levels availability becomes a barrier to use. This would require funding but would not need to be repeated often.

Box 1. Sangini in the broader social franchising context

Over the past two decades, social franchising has become an important strategy for increasing access to FP methods that require a clinical procedure (e.g., implants, IUDs, and permanent methods). Social franchising goes further than traditional product social marketing by supporting clinical training and monitoring, skills transfer, quality assurance, and provider behavior change. The franchisor also offers franchised providers a shared brand identity, marketing support, and training in business management practices in exchange for adherence to quality standards (supported by a written agreement or memorandum of understanding) (Nepal-WHO CCS, 2018-2020).[5]

Examples of social franchises in the South and Southeast Asia region include Greenstar in Pakistan, Smiling Sun in Bangladesh, and Sun Quality Health in Myanmar, all of which have benefitted from diverse, long-term donor support to maintain relatively high levels of support for training, quality assurance, and marketing.

Though launched as the world's first social franchise, Sangini has been overtaken by franchisors in the region that are providing a higher level of support to franchisees who are offering a wider range of FP services. Indeed, Sangini retains few of the attributes of a social franchise:

Branding and marketing: though the Sangini brand is widely known, service points are often not branded; Sangini injectables are reported to be available outside the network; and CRS has little funding to promote the brand promise as a means to increasing mCPR.

Quality standards: Documentation and dissemination of CRS quality standards remains a work in progress and a specialized supervision function has only recently been established at the head office.

Training and quality assurance: Largely due to resource limitations, training opportunities for providers are more limited than in other franchises, and CRS does not have the resources to reach all service delivery points even once a year; the ratio of QAOs to service delivery points is considerably lower than benchmarks within and outside Nepal.

Written agreements: It has not been standard practice for CRS to require Sangini service points to agree in writing to uphold network standards.

Given the current state of Sangini and likely continued resource constraints, one question is whether a fully-developed social franchising model is a necessary aspiration. If the objective is to ensure that injectables are widely and safely available, then something less than a franchising model might be sufficient. Would a certification and verification model meet the objective? This would be leaner than a social franchise, but additional funding would still be required for certification and monitoring. If the objective is to drive increases in mCPR by delivering a full range of contraceptive options, then social franchising would be valuable, but the qualifications of most Sangini service points are inadequate. CRS would need to build on its experience and strengthen its offering in training, supervision, and marketing to establish relationships with a different set of providers (as other SMOs in Nepal are currently doing), which would require considerably more funding.

[5] See http://www.ghspjournal.org/content/3/2/180 and http://www.sf4health.org/about-social-franchises for further discussion of contrast between social franchising and social marketing

Progress Toward Institutional Development Objectives

Increasing the sustainability of CRS is a key GGMS objective. IRs and sub-IRs included in both phases measure sustainability in terms of financial independence from donors, improved institutional capacity, and reduced dependence on technical assistance. Increasing cost recovery is identified as a critical component of achieving financial independence.

As noted above in the Project Background, CRS was to achieve these institutional development objectives through a range of activities supported by FHI 360 in Phase 1 and SHOPS Plus in Phase 2. Both phases included a range of capacity-building initiatives. Phase 1 emphasized functional areas such as accounting and procurement. Phase 2 emphasizes technical areas like marketing and research. These activities and their outcomes are summarized in Table 4 and Table 5. In Phase 2, the RF included one IR, two sub-IRs, and 11 indicators related to the increased sustainability of CRS. The MEL plan includes the same IR but reduces the number of indicators substantially. The assessment report presents data on all Phase 2 indicators from the RF and the MEL plan as this provides a fuller picture of institutional evolution.

Given the importance of cost recovery in the RF, this report includes a more detailed analysis of current rates and scenarios for increasing the rates. The report also includes an additional discussion of how technical assistance (TA) is being used and the impact of the TAP on CRS.

Summary findings on institutional development

CRS is making progress toward the sustainability indicators related to cost recovery. Though the Phase 1 targets for achieving "full cost recovery" on four products and "product cost recovery" on eight products were not achieved, it is still possible for CRS to meet the MEL plan target of 58 percent average cost recovery across all products by the end of the project. The average is currently at 45 percent. A combination of further price increases and some cost reduction could achieve this target.

CRS is making progress toward institutional development objectives. CRS is likely to achieve the MEL plan target of a 3.0 score on the Social Marketing Organization Development Assessment Tool (SMODAT) having improved from 2.3 in 2017 to 3.1 in December 2018. This improvement reflects a number of positive changes in functional and technical processes and systems within CRS. However, there is variability in scores across the SMODAT and some critical components lag behind – such as fundraising and developing unrestricted reserves. More work is also needed to move CRS from merely performing certain functions to performing them with the quality and sophistication of a high-performing social marketing organization (SMO). This could be reflected in the next iteration of SMODAT standards, which were designed to be revised upwards once current standards are met. Importantly, CRS will need to strengthen a culture of sustaining technical improvements post-GGMS. This will be critical as CRS presents itself to donors as an efficient, evidence-based implementer.

Box 2. CRS's sustainability challenge in context

CRS has maintained continuous operations as a not-for-profit social marketing company for 40 years. Many NGOs (and for-profits) would envy this level of "sustainability". Yet CRS has been dependent on USAID for its existence, which puts it at risk when USAID priorities and funding levels change. What can CRS learn from other social marketing organizations (SMOs) as it pursues a sustainability strategy that reduces the risk of dependence on one donor?

Most NGOs around the world in developing (and developed) countries sustain themselves through donor funding. These NGOs view their mission as ongoing – not something transitional or to be phased out. Most do not have significant sources of "earned income" (sales revenue, user fees, etc.). Their "sustainability strategy" is to attract donor funds. They make themselves attractive to donors in part by demonstrating that they can deliver value efficiently to populations underserved by governments and for-profit businesses. Financial independence from donors is not a goal.

SMOs in developing countries have often been asked to aspire to a different standard: financial independence from donors, achieved by generating enough sales revenue to cover their costs. Unlike many NGOs, SMOs generate sales revenue, which makes financial "self-reliance" an attractive option. Yet, at same time, SMOs are frequently asked to reach the most vulnerable populations, those hardest-to-reach. Indeed, reaching these populations aligns with many SMOs' missions, even though these populations are expensive to reach. This mixed message – a mandate to increase cost recovery to become self-reliant yet also reach the hard-to-reach – creates a tension that is often left unresolved.

A different approach to SMO sustainability would be to put SMOs within the broader category of NGOs who sustain needed programs with (at least in part) donor funding or public funding from national governments (e.g., through "contracting out" mechanisms). In that context, SMOs would be evaluated on whether they can use public and philanthropic money effectively. Can they use subsidies efficiently and target subsidies to those who need them? Early on, there was consensus that an effective use of subsidy was to reduce the price of products available to everyone. These were needed investments when health product markets were less mature. As markets have evolved, there is less need for generalized subsidies and much of the product side of SMO operations can start to look like a social enterprise sustaining itself with sales revenues.

But a SMO's mission doesn't end with graduating some products to a social enterprise model. There are still people who will go unserved – still people facing barriers to adopting healthier behavior. Are SMOs capable of using public funds to reach them? Do they have a comparative advantage in using social marketing skills to change behavior? Can they do that more efficiently than the government? Have SMOs made the case that they are attractive options to governments for contracting out services – including behavior change communications, service delivery, and consumer research?

Seen in this broader context and with part of its portfolio operating as a social enterprise, the sustainability question for CRS would be: What would it take to make the case to donors and government that CRS can efficiently add value to public health goals by using public money for programs that go beyond selling subsidized products to the general population? Investments in institutional development would be driven in large part by the answer to that question.

Phase 1 major achievements in institutional development

- CRS installed an enterprise resource planning (ERP) system (the "NAV") that integrates existing vertical systems (e.g., finance, logistics, human resources, monitoring, and evaluation) into a single platform. The NAV improves accountability and gives management increased visibility into key metrics for monitoring organizational performance, including cost recovery rates

- With support from FHI 360, CRS designed and launched the first round of the RAI in Jumla, Bardiya, and Bajhang districts. The RAI provides CRS with an opportunity to engage in more intensive SBCC with harder-to-reach populations.
- CRS assumed all procurement responsibilities for Nilocon White (OCP) and Panther Premium (condom), increasing CRS's capacity to take ownership of its supply chain, which forms the foundation of its operations.

Phase 2 major achievements in institutional development

- Increased cost recovery primarily by increasing prices of all three condoms and Sunaulo Gulaf in 2017 and Nilocon White in 2018. CRS also reduced the number of Rural Field Representatives and more closely managed distribution vehicles to reduce costs.
- Designed and implemented the SMODAT to assess CRS's organizational strengths and weaknesses, and developed a prioritized action plan for improvements.
- Collaborated with SHOPS Plus on the design and implementation of multiple quantitative surveys that improved CRS's capacity to make evidence-based decisions. CRS staff specifically cited the surveys related to outlet coverage, including the hot zone mapping and lot quality assurance sampling approach, as enabling CRS to refocus its distribution efforts for more efficiency as well as the qualitative study in the first round RAI districts as crucial to reorienting BCC activities in the second-round districts.
- Applied the NAV to develop a more rigorous approach to estimating average cost recovery across its portfolio by more accurately allocating expenses from multiple projects to individual brands. The NAV has also enabled the first iterations of dashboards to communicate essential performance data to managers.
- Established a monitoring and evaluation unit, human resources unit, and a procurement unit which now procures eight of 12 products independently.
- SHOPS Plus has worked with CRS to revitalize its approach to marketing plans. Marketing plans, which are the principal guiding document for SMOs, had previously been less consistently developed and with less supporting evidence.
- CRS negotiated a de minimis rate for indirect costs which it plans to use, in part, to develop proposals for new projects and products, public relations and corporate communication, governance activities, and employee skill development.
- SHOPS Plus is in advanced stages of developing mobile applications for Sangini QAOs. This should enable much more rapid and flexible analysis of data from TSVs, and offers the potential to increase quality in the network.

Table 4. Phase 1 achievements against IR 3: CRS achieves full cost recovery with at least two products and product cost recovery with at least another two products

Sub IR	Indicator	Target	Achieved
3.1: Increased use of better business models, tools, and techniques for cost recovery and surplus revenue	Number of products that achieve full cost recovery[6]	4	☒ 1
	Number of products that achieve product cost recovery	8	☒ 7
	Ratio of CRS product costs to USAID product costs	80%	☒ 71%
	USAID shared cost ratio	65%	☒ 58%
3.2: CRS financial management system disaggregates accounting by products and donor support	Number of financial reports produced without assistance	Targets for these indicators were included in the PMP but totals achieved were not included in annual reports. Annual reports do refer to a number of activities. Based on that it seems likely that targets for staff training were reached if not exceeded; targets for collaborative meetings likely fell short.	
	Number of CRS staff trained in cost accounting		
3.3: Increased collaboration between private sector, donors, USAID partners, and GON public sector health services in FP, maternal and child health and HIV/AIDS and STI prevention products and services	Number of meetings and interaction sessions conducted		

Sources: CRS annual reports and PMP

6 Per CRS's 2014/5 Annual Report, e-CON (ECP) had achieved full cost recovery; Nava Jeevan (ORS), Clean Delivery Kit, Piyush, CURe (STI Kit), Panther Condom, Nilocon White (OCP), and D'zire Condom had achieved product cost recovery; Dhaal Deluxe Condom, Sunaulo Gulaf (OCP), Sangini (injectable), Jadelle Implants, and IUDs had achieved neither.

Table 5. Summary of Phase 2 RF and MEL institutional development indicators, targets, and progress

Indicator	Progress
SMODAT score (RF and MEL)	Scored a 3.1 in last round in December 2018. Likely to achieve the target of 3.0.
Average cost recovery rate across all CRS products (RF and MEL)	Currently at 45% based on CRS internal calculations for 2018/9. Possible to achieve 58% in final year but will require more aggressive approach to pricing and cost reductions and/or dropping lower cost recovery products from the portfolio.
Cost per product distributed (RF)	No target. A good indicator to judge the range of cost recovery within the portfolio. Per CRS's current calculations, two products are at full cost recovery and seven recover commodity and packaging (COGS).
Number of donors or funding organizations contributing to CRS (RF)	No target. CRS has not yet added any significant donor funding beyond USAID and KfW. Success would be more likely with a greater investment in new business development, which remains an under-resourced function within CRS.
Level of CRS unrestricted funds (RF)	No target. CRS does not appear to have developed a path to generating unrestricted funds as the de minimis overhead rate from USAID should theoretically be dedicated to covering indirect costs. No donors provide CRS unrestricted funding or pay fees in excess of costs.
Updated, evidence-based marketing plans exist for all CRS products (RF)	No target. Marketing plans have improved in quality with support from SHOPS Plus during Phase 2. More progress is needed to demonstrate systematic application of consumer insight and market segmentation to the challenges of growing use. This progress would help demonstrate CRS's commitment to increasing its behavior change capabilities, which would make it more attractive to other donors.

Indicator	Progress
Updated employee procedures manual used, performance appraisal system contributing to staff accountability for performance (RF)	CRS has conducted staff training on a new performance appraisal system with SHOPS Plus support. At the end of 2018, all staff had new objectives and KPIs for their next performance evaluations taking place in July 2019.
HR policies developed and implemented (RF)	CRS's Board of Directors approved the revised by-laws which were disseminated to all CRS staff. CRS still plans to produce an Employee Handbook that provides more practical guidance on day-to-day personnel and operational issues that are not covered in the by-laws.
Payroll is processed using a timesheet system and level of effort is charged to the appropriate project or funding source (RF)	As of 2018, CRS had integrated timesheets with the payroll system in the NAV allowing for tracking level of effort across projects and funding sources.
Costs are allocated across projects and funding sources in a consistent and proportional manner (RF)	The NAV allows CRS to allocate expenses from all projects across different products to calculate both a product-wise cost recovery rate and an average cost recovery rate across the portfolio. They are now doing this more thoroughly than many SMOs.
Time taken to resolve negative audit findings (RF)	SMODAT score improved from 2 to 3, indicating meeting standards for this indicator.

Sources: CRS and SHOPS Plus annual reports, SMODAT report, and interviews

Analysis of cost recovery

Increasing the percentage of CRS expenses supported by revenue generated from the sales of products cost recovery is another key GGMS objective. Higher cost recovery reduces CRS's dependence on USAID – a key sustainability strategy. The Team analyzed CRS's cost recovery methodology, cost recovery trends since the inception of GGMS, and potential future scenarios for achieving higher cost recovery.

Key takeaways:

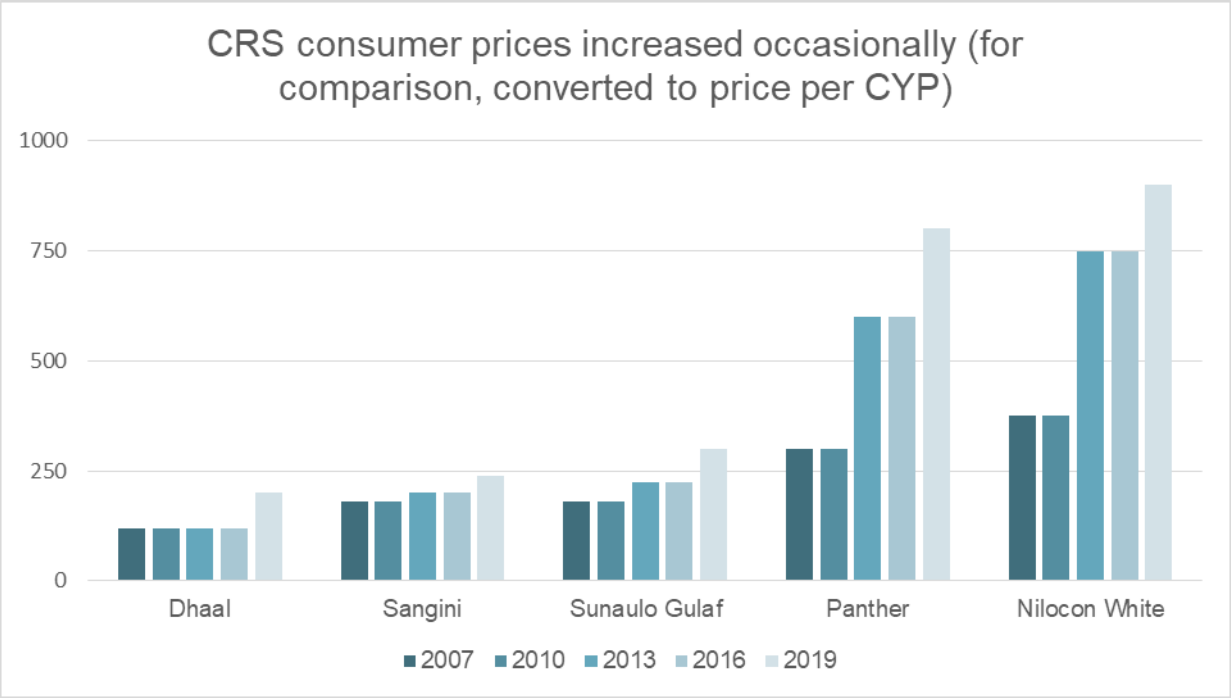
- Achieving the MEL plan target of 58 percent average cost recovery across all products is possible but would require more aggressive price increases and/or dropping lower cost recovery products (such as Dhaal) from the portfolio. As shown in Figure 2 and Figure 3 below, CRS's relatively few price changes over the last 12 years have generally not kept up with inflation. Specifically, the cost per CYP for Dhaal, Sangini, and Sunaulo Gulaf have all decreased in inflation-adjusted terms over that period. Decreasing costs, including by reducing CRS's level of effort in hill and mountain areas and/or procuring Nilocon White from non-SRA sources, would also contribute to improving average cost recovery. These changes come with trade-offs and would have varying impacts on CRS's ability to serve harder-to-reach populations.
- Average cost recovery has limited usefulness as a performance metric given the diversity of products in the CRS portfolio and the different population segments and geographic areas CRS is intending to reach with different products. For example, some segments have a stronger justification than others for continued subsidy to achieve health goals.
- CRS's methodology for allocating indirect costs in proportion to sales volume likely overstates, in comparison to other possible methodologies, the amount expended on Dhaal and Panther. This drives down their apparent cost recovery rates while understating expenses for Nilocon White and e-CON that drive up their cost recovery rates.

Methodology for calculating cost recovery

CRS separates direct costs from indirect costs. Direct costs include commodities, packaging (including labor) and promotion directly linked to one product. Indirect costs include expenses shared across all products, such as management salaries, vehicle fleet, and rent. CRS defines "product cost recovery" as product sales revenue divided by direct costs. "Cost recovery" is defined as sales revenue divided by the sum of all costs attributed to that product. The "average cost recovery rate" is defined as total sales revenue divided by CRS's total costs.

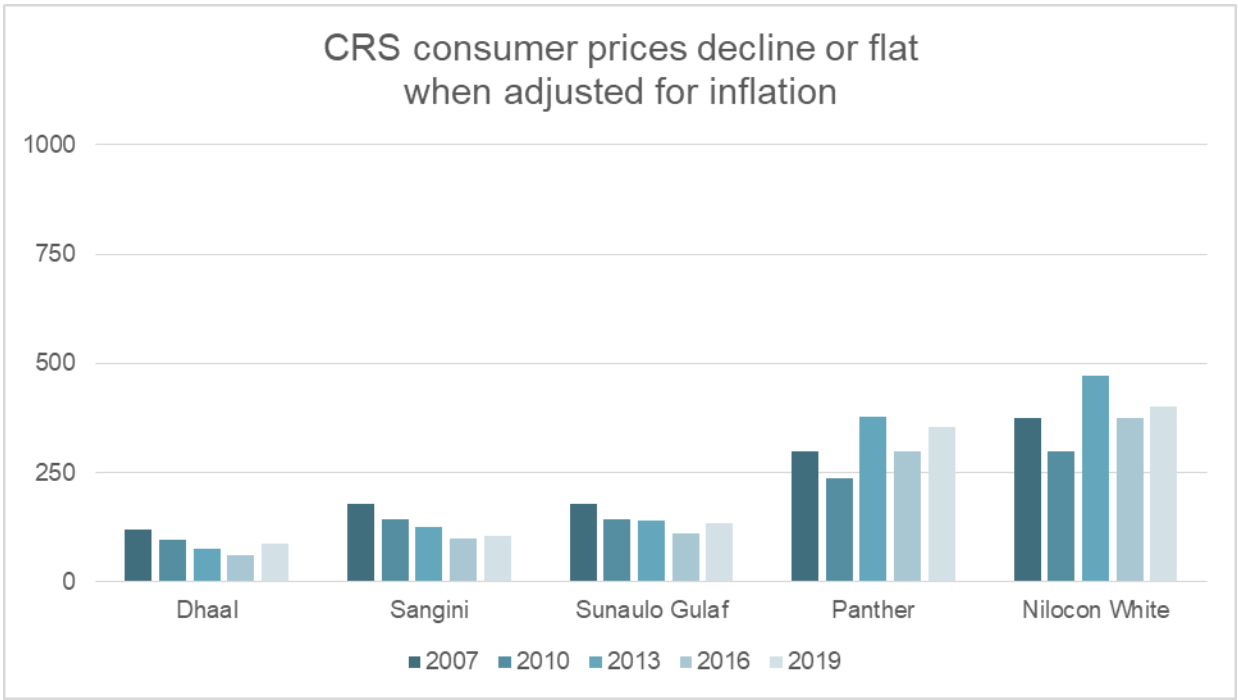
There is no universal methodology for allocating indirect (i.e. shared) costs across a diverse portfolio. While the choice of methodology does not affect CRS's overall average cost recovery, it does affect each individual product's cost recovery rate. CRS allocates indirect costs in proportion to the units sold for each product. For example, if CRS sells 15 million units of product of which 5 million units are Dhaal, then Dhaal would be allocated 33 percent of CRS's shared costs.

Figure 2. Consumer price changes for CRS products



Source: CRS internal pricing reports converted to CYP using standard factors for each method

Figure 3. Consumer price per CYP adjusted for inflation*



Source: CRS internal pricing reports converted to CYP using standard factors for each method
* Based on various sources, assumed a rate of 8% per year through 2016, then 4% per year

Another possible methodology is allocating shared costs according to the proportion of sales revenue from each product which would, for example, reduce Dhaal's share of costs and increase D'zire's share. CRS could also assess of the level of effort required for each product which could, for example, allocate more costs to products that primarily serve areas that are more difficult to reach.

CRS's actions related to cost recovery are mostly related to changes in pricing, which have increased sales revenue. While CRS has made some efforts to contain operational costs, these have likely had a small impact on cost recovery.

Results

- For the last full financial year covering August 2017 through July 2018, CRS achieved a 48 percent average cost recovery rate. The rate for the current partial year is 45 percent.
- CRS recovered 78 percent of direct costs (i.e., total sales revenue was 78 percent of the cost of products, packaging, and promotion).
- Nilocon White (OCP) and e-CON (ECP) achieve more than full cost recovery.
- Sunaulo Gulaf (OCP), Nava Jeevan (ORS), and CDK achieve product cost recovery. Panther and D'zire (condoms) were close to product cost recovery last year and are achieving that level so far this year.
- Dhaal and Sangini account for 71 percent of the loss generated by CRS as measured by the difference between sales revenue and costs.

Scenarios that achieve the MEL plan target

The Team developed several scenarios to explore what it would require for CRS to reach the MEL plan cost recovery target (or higher) through price increases, cost reductions, and changes to the product portfolio. The scenarios should be considered only as a starting point for discussion as they make several simplifying assumptions. For example, except where noted, they assume sales remain constant, which would not happen in practice.

The scenarios apply an indirect cost allocation methodology that averages the "by volume share" methodology (used by CRS) and the "by revenue share" methodology. This seemed more likely to reflect actual costs by product and the potential cost reductions that would occur if one or more products were removed from the portfolio. The scenarios also use a private sector approach to separating costs into "cost of goods sold" (COGS), which includes only commodity and packaging costs. This allows for a conventional calculation of "gross margin", which is the amount of profit or loss generated by a product before accounting for non-COGS costs. Finally, the scenarios assume that CRS will be able to purchase Nilocon White at the same (lower) price of Sunaulo Gulaf as would happen if CRS were not using donor funding or program income subject to USAID rules. Under these scenarios, only Nilocon White is currently at full cost recovery. e-CON is close at 98 percent. Refer to Table 6 for a summary of all scenarios.

Findings from the cost recovery scenarios:

- **Increasing sales revenues by 25 percent would achieve the 58 percent average cost recovery target**. This would essentially require a 25 percent increase in prices to

consumers, though this increase would not need to be applied evenly across the portfolio. For example, given Panther's price relative to other condoms in the market, and the likely willingness to pay of consumers, there is likely room to increase the price of Panther. CRS plans to introduce a new variant of Panther at a higher price in 2019.

- **Decreasing non-commodity costs by 16 percent while increasing sale revenue by 16 percent would also achieve the 58 percent average cost recovery target**.
- **Eliminating Dhaal from the portfolio would increase the average cost recovery to 52 percent.** Dhaal currently accounts for nearly 25 percent of CRS's losses. NDHS 2016 suggests there would be a low risk to mCPR from discontinuing Dhaal. Users in higher wealth quintiles would likely switch to other CRS or commercial brands. In the lower two quintiles, only 3percent use condoms for contraception and nearly 75 percent of those already use non-CRS brands. Alternatively, CRS could build on Dhaal's brand equity by switching to featured variants using the same brand name but at a considerably higher price.
- **Eliminating Sangini from the portfolio would increase average cost recovery to 57 percent.** Sangini likely accounts for as much as 45 percent of CRS's losses. This would clearly have a large impact on mCPR given Sangini's market share across Nepal since there are no other commercially-supplied injectables to take up the market share if Sangini disappears. An alternative approach is to consider Sangini outside the average cost recovery calculation given the presumed need for continued subsidies for injectables as well as the need to increase spending to improve quality in the network.
- **Limiting the portfolio to D'zire, Nilocon White, and e-CON (the three products that cover the highest percentage of COGS) would increase average cost recovery to nearly 100 percent.** This would clearly have an impact on CRS's CYP and impact, but would essentially turn the organization into a sustainable social enterprise. A modest increase in the price of D'zire would transform CRS into a profitable enterprise.
- **Pursuing an urban focus, assuming that would result in a 40 percent decrease in revenue but a larger decrease of 60 percent in indirect costs, would increase average cost recovery to 59 percent.** Pursuing an urban focus without Dhaal would increase cost recovery to 66 percent.
- **There do not appear to be scenarios in the medium-term that would generate enough gross margin ("profit") from one set of products to provide meaningful subsidies to other products**. This type of "cross-subsidization" is sought after by many SMOs but, in practice, there have been few successful examples. SMC in Bangladesh is one exception attributable to vertical integration into a large ORS market developed collaboratively with partners and donors over decades. DKT is an example of cross-country subsidization.

Table 6. Summary of cost recovery scenarios

CRS cost-recovery analysis
Baseline and future scenarios

*Indirect costs allocated as average of by-volume and by-revenue methods

Baseline (from 2017/18 data)

		Costs						% Cost Recovery		
Category	Brand	COGS	All Other*	Total	Sales revenue	Gross Margin	Profit/Loss	of COGS	of All Other	of Total
Condom	Dhaal	9,609,044	12,808,393	22,417,436	2,636,092	-6,972,952	-19,781,344	27%	21%	12%
Condom	Panther	6,602,604	11,472,535	18,075,139	7,349,932	747,328	-10,725,207	111%	64%	41%
Condom	Dzire	2,004,416	5,631,542	7,635,958	4,498,097	2,493,681	-3,137,861	224%	80%	59%
ECP	e-CON	1,916,074	7,372,118	9,288,192	9,105,520	7,189,446	-182,671	475%	124%	98%
Injectable	Sangini	41,797,288	8,666,606	50,463,894	13,040,140	-28,757,148	-37,423,754	31%	150%	26%
OCP	Nilocon White	4,601,034	11,604,652	16,205,686	19,275,234	14,674,200	3,069,548	419%	166%	119%
OCP	Sunaulo Gulaf	3,863,563	4,020,509	7,884,072	4,948,927	1,085,364	-2,935,145	128%	123%	63%
ORS	Navajeevan	9,158,420	12,146,420	21,304,840	10,551,500	1,393,080	-10,753,340	115%	87%	50%
Implant	Jadelle	467,353	89,660	557,012	182,000	-285,353	-375,012	39%	203%	33%
IUD	IUD	133,600	56,718	190,318	108,400	-25,200	-81,918	81%	191%	57%
CDK	Improved CDK	38,896	23,561	62,457	39,343	447	-23,114	101%	167%	63%
STI Kit	Cure	22,759	19,810	42,569	22,620	-139	-19,949	99%	114%	53%
Total	Total	80,215,050	73,912,524	154,127,574	71,757,806	-8,457,244	-82,369,768	89%	97%	47%
Future scenarios										
1. Revenue +25%		80,215,050	73,912,524	154,127,574	89,697,258	9,482,208	-64,430,316	112%	121%	58%
2. AOC -16%, Revenue +16%		80,215,050	62,086,520	142,301,570	83,239,055	3,024,005	-59,062,515	104%	134%	58%
3. No Dhaal		70,606,006	61,104,131	131,710,138	69,121,714	-1,484,292	-62,588,424	98%	113%	52%
4. No Sangini		38,417,762	65,245,918	103,663,679	58,717,666	20,299,904	-44,946,014	153%	90%	57%
5. Social Enterprise Basket (Dz,ECP,NW)		8,521,524	24,608,312	33,129,836	32,878,852	24,357,328	-250,984	386%	134%	99%
6. Urban Focus (Sales -40%, AOC -60%)		40,391,108	29,565,010	69,956,117	41,402,258	1,011,151	-28,553,859	103%	140%	59%
7. Urban Focus & No Dhaal		36,547,490	24,441,653	60,989,143	40,347,822	3,800,331	-20,641,321	110%	165%	66%

CRS use of technical assistance

CRS has received TA from two international NGOs during GGMS: FHI 360 in Phase 1 and SHOPS Plus in Phase 2. Both TAPs provided support on improving CRS's institutional capacity, financial sustainability, and coverage in rural areas. FHI 360 focused somewhat more on developing staff through trainings and on management systems while SHOPS Plus has focused somewhat more on social marketing technical capacity based on its 2015 assessment of CRS. Refer to Annex 4 for a list of TA activities supported by the TAPs.

CRS has used much of this TA to improve it operations. As noted above, this includes the NAV to improve financial management, trainings to improve staff performance, and qualitative and quantitative surveys to improve programmatic performance.

Most CRS staff cited positive relationships and interactions with the TAP staff and appreciated the value they are adding. However, interviews with current and former TAP staff, CRS staff, and stakeholders did raise issues for the Assessment Team regarding CRS's commitment to change, its ability to absorb TA, and the manner in which TA is provided:

- Some stakeholders felt that CRS is not acting with enough urgency to change in an evolving context (see Box 3 on CRS and Organizational Change).
- The SMODAT and various analyses, reports, assessments, and studies have generated a list of recommendations that may be too expansive for CRS to act on. While CRS has agreed to implement most of the recommendations, they have not yet acted on many.
- With respect to the analyses, reports, assessments, etc., it was not clear to the Team whether CRS was embracing many of them as necessary activities or more as something required by the TAP and the donor. When one CRS staff member was asked why she worked with the TAP on a particular issue, she replied that she "felt the need" to fix a problem; that reaction seemed to be more the exception than the norm.
- Some CRS staff felt that the TAP recommendations were not informed enough by the context in Nepal, and TAP were not always open to adjusting recommendations based on context.
- TA has not always sufficiently probed the "root causes" of underperformance against benchmarks. The Team did not find documentation looking at lessons learned from over 40 years of providing TA to CRS, which might have informed current approaches.
- Additional focus on participatory approaches to setting a capacity-building agenda based on self-identification of priority challenges facing the organization might help CRS increase ownership of the institutional development agenda. This could be complemented with periodic reference to tools such as the SMODAT for benchmarking priority areas.

Box 3. CRS and Organizational Change

"*Nepal is slow to change. CRS is slower." – Key informant*

The Team was struck by the contrast between what some stakeholders expressed as a strong desire to see CRS evolve more rapidly and the pace of change within CRS. Although CRS has maintained a large distribution network that delivers an important share of Nepal's mCPR, it seems fair for stakeholders to ask why CRS has not evolved as many of its peers in the region have. After 40 years, CRS does not have a diversified donor base; pioneering work in fractional social franchising has been overtaken by others in the region with networks offering a broader range of FP services with a higher focus on quality; and CRS is still striving to adopt a wider range of evidence-based marketing and behavior change approaches.

Part of the relatively slower pace of evolution can be attributed to funding levels. The current GGMS project, for example, is relatively under-funded for behavior change activities and supportive supervision. The Team also felt that there are internal factors at play in slowing the pace of change (identifying these factors would benefit from more discussions and focus groups with staff and stakeholders). There are many frameworks for examining these factors. Four steps adapted from John Kotter's "Heart of Change" (Kotter, 2002) shed light on CRS's challenges moving forward and suggest changes in the approach to TA:

1. Create a sense of urgency. The starting point for change is to recognize the urgency of problems and opportunities so that staff are telling each other "we must do something". This means reducing the complacency and fear that can prevent change from starting. Interviews suggest urgency is felt by stakeholders more strongly than by CRS. Urgency can be strengthened by looking at opportunities peer organizations are exploiting that CRS may be missing. A sense of urgency can also come from (or be weakened by) signals sent by donors. The urgency to achieve financial independence can be undermined by the experience of 40 years of continuous USAID support. What can be done to create more urgency?
2. Build a guiding team. Pulling together the right group of people with the right skills and sufficient power can drive change. This is an area where CRS is making progress. There are individuals within CRS who are embracing change – especially with the creation of new functional and technical positions within CRS. What can be done to build that into a cohesive team that feels the responsibility and empowerment to lead change?
3. Get the vision right and communicate for buy-in. Organizational change efforts are strengthened by expressing them as part of vision for who the organization wants to be and where it wants to go. Then clear messages need to be sent throughout the organization so that the vision becomes second nature to staff. Can CRS's strategic sustainability planning exercise be used as an opportunity to define the vision for change and communicate it to staff?
4. Create short-term wins. It is important to generate sufficient wins fast enough early on to drive out any initial cynicism and skepticisim about the change process. Successes can be small and short-term but should be visible, unambiguous, and speak to what people care about. The new ERP system (NAV) is one visible success on the path to becoming an efficient, data-driven SMO. What other wins can be identified and communicated?

Factors Influencing Performance and Considerations For Future Projects (Institutional Development)

- Increasing average cost recovery was made more challenging by the concurrent mandate to reach hill and mountain districts and to improve quality within Sangini. Both are initiatives that cost more than distributing products in urban and peri-urban areas. Future

programs could reduce that tension by setting objectives for cost recovery rates for a basket of “social enterprise” products within the overall portfolio.

- While it is important to seek efficiency in all product marketing, average cost recovery rates are a weak indicator within a diverse product portfolio. The Phase 1 indicator related to the number of products achieving full cost recovery likely creates a better incentive to develop a product basket that can sustain itself while still hitting minimum impact targets.
- Adopting a more evidence-based approach costs money. CRS’s average cost recovery rate, and cost per CYP, would be higher if it also incorporated (as many SMOs do) research costs now included in SHOPS Plus’s budget.
- Reporting against an aggregate SMODAT score as required by the MEL plan may hide areas of concern or high priority. The Phase 2 RF is less likely to do so as it identifies specific priority areas for improvement.
- Future programming should consider how to create a greater incentive for organizational change. Stakeholders perceived that the predecessor N-MARC project created a greater sense of urgency for CRS because it invested in PPPs with manufacturers that were, in a sense, alternatives to CRS. However, the manner in which this is done is critical. A previous project with PSI, presumably designed to stimulate CRS, was perceived by CRS and stakeholders as undermining CRS.
- Though there are several areas where CRS falls short of standards as defined in the SMODAT, focusing TA on fewer areas in a more concentrated way might yield longer-lasting organizational change. CRS should consider identifying these needs in its strategic planning process as it looks at the capacities needed to succeed.

4. Impact of GGMS on the Private Health Sector

Context

Social marketing programs have generally had a positive impact on health markets in developing countries over the past few decades. Supported by donor subsidies, SMOs have often been the first to make health products widely available at prices affordable to the general population. This is true of CRS: in its early days, CRS was a pioneer in introducing contraceptives in Nepal. Social marketing programs have also reduced barriers to market entry and increased consumer demand. As markets have evolved, the need for universally-subsidized products has diminished, and the continued presence of subsidized social marketing brands in some contexts may inhibit (or "crowd out") the expansion of the commercial sector. To the extent public funding could be used more effectively elsewhere, continuing untargeted subsidies may negatively affect the pursuit of public health goals.

In this evolving context, stakeholders are increasingly focusing on the overall "health" of a market, characterized by increased informed demand, increased product use, increased equity, and decreased dependence on external donor subsidy. Some countries have started to adopt a TMA to consider the contributions of all sectors in a market (commercial, NGO, and government) in meeting public health goals. Under a TMA, donors and market players make deliberate choices – in procurement, distribution channels, pricing, regulations, public-private partnerships, etc. – to build a healthier market in support of national goals. SMOs have been challenged to apply their skills in support of a TMA, moving beyond marketing products at subsidized prices.

Unlike the N-MARC project which preceded it, the GGMS project design did not include goals or activities intended to improve the health of contraceptive and MCH product markets. Though CRS maintains strong relationships with its manufacturing and distribution partners, GGMS has not leveraged resources from the private health sector nor contributed directly to the strengthening of private sector organizations or associations. From the private sector side, distributors, wholesalers, and retailers have not contributed time or resources to the project, (beyond commercial transactions) and media companies have not given the project concessionary rates. Under GGMS, CRS has generally not engaged actively in advocacy efforts that would benefit the entire private sector as this was not an area of emphasis in the project design.

Though CRS does have a good track record of increasing private sector engagement in health markets from its earliest days (as noted above, primarily in increasing access), it does not appear that CRS has added to this legacy under GGMS. It is more likely that the project is having a modest negative effect on commercial product markets in the sense that, other than condoms, there have been no new commercial entrants of meaningful size. The project may be crowding out commercial players who could otherwise serve more people without subsidies. This negative impact is not surprising given, again, the project's design, deliverables, and activities, which emphasize CRS sales.

The impact of GGMS activities on commercial sector is discussed in the context of the overall health of product markets below.

Regarding FP services, CRS continues to have a positive impact on quality through training and supervision of Sangini service points. As noted in the preceding section, resource constraints limit the extent of this positive impact on providers.

Health of Product Markets

A positive impact on the total market would be characterized by some or all of the following occurring as a direct or indirect result of project activities:

- Increasing product use as shown by NDHS or other population-based surveys for products not covered by the NDHS. For the contraceptive category, a healthier market would result in increased mCPR.
- Increased informed demand for products, such as improvements in consumer opportunity, ability, and motivation as measured by population-based surveys.
- Growth in the total market size (all sectors considered).
- Greater consumer choice shown by growth in number of brands available.
- Less dependence on external (i.e., not from national government) subsidy measured as the value share of subsidized products in the market decreasing. This would typically result from increased prices for social marketing brands and/or an increased volume share of commercially-priced products.
- No evidence of crowding out of commercial brands.

The Team analyzed available data and used key informant interviews within the private sector to assess changes in the market during the GGMS project period. See Table 7 for CRS's impact on markets.

Considerations for Future Programs (Impact on Private Sector)

- Programs are more likely to have a positive impact on the private sector and the overall health of the market if they apply TMA principles and make deliberate investments in private sector engagement.
- A sustained, active effort around market stewardship and facilitation led by the GoN would help orient all actors in the market, including CRS, and increase the likelihood of maximizing contributions from all sectors to meet more unmet need.
- A greater emphasis on generating "public goods" – e.g., behavior change interventions and demand generation activities that benefit all brands within a category as well as data collection and dissemination, especially to share insights about consumer needs – would also help to drive use.

Table 7. CRS impact on markets

	Use & Market Size	Market Dynamics	Takeaways
Contraceptives	Modestly negative trend. Modern method CPR declined from 43.2 to 42.8 between NDHS 2011 and NDHS 2016 Market size is likely not growing overall, or only in proportion to the small growth in WRA.	Neutral trends except for condoms, which has been positive. Many commercial condom brands, but few hormonal contraceptive brands available other than CRS brands Total market may be slightly less dependent on subsidy since CRS's share of condom market is down and CRS OCP prices have increased (but that accounts for less than 10% of mCPR and the % sourcing from public sector has increased from 69.0 to 69.5)	Overall the market has not become healthier during GGMS considering: • Use has not grown • Market has not grown • Many categories still dominated by few (CRS) brands • Likely no change in dependence on external subsidy, which creates potential vulnerabilities. Refer to Figure 4 and Figure 5

	Use & Market Size	Market Dynamics	Takeaways
Condoms	Modestly positive trend. Condom use as a contraceptive method decreased slightly between the last two NDHS (4.3% to 4.2%); condom use at last paid sex has increased but accounts for a small part of the market (less than 1% of males report paid sex) Nielsen survey data from the formal private sector shows a condom market that did not grow from 2015 through 2017	Mostly positive trend. Number of brands has grown (though some of that occurred before GGMS), adding depth to the market CRS has a declining market share per Nielsen; it has also increased prices modestly, but still uses donor funding to provide a substantial subsidy on market leaders Dhaal and Panther Overall the market is likely less dependent on subsidy, since CRS's share has dropped substantially; but consumers are apparently shifting more toward government sources (32.3% to 38.4%) and away from private sources (59.3% to 56.8%) per the last two NDHS	Relatively healthy category that has gotten healthier during GGMS with greater private sector role, even if it does not appear to be growing overall: • Significant competition among brands • Price increases on Panther and D'zire (which are still priced at less than half of the lower-priced commercial brands) would continue to level the playing field while likely not risking large impact on use

	Use & Market Size	Market Dynamics	Takeaways
OCPs	Neutral trend. Slight increase in use of OCPs between last two DHSs (4.1% to 4.6%) There is growth in private market due to an increase in CRS's sales but CRS reports that some of this may be attributable to filling gaps caused by public sector supply issues.	Neutral trend. In the private sector, CRS continues to dominate with more than 90% market share (per Nielsen) CRS's recent price increases slightly decrease dependence on subsidy, but more people are sourcing from government (50.9% to 56.1%) and less from the private sector (44.6% to 40.3%) per NDHS.	Private market nearly totally dependent on CRS. Though CRS's market leader Nilocon White is likely at full cost recovery, new entrants do not have the same benefit that CRS has in terms of donor funding to build brand equity and infrastructure; and Sunaulo Gulaf is still subsidized which creates a further deterrent for the private sector.
Injectables	Similar story to OCPs to be fleshed out. About same place in method mix; have been large increases in CRS sales in last two years; can't tell if that is just taking market share	More people sourcing from government	High subsidy suggests crowding out but not clear what would happen if prices were increased with a lower-priced option for some consumers.
ECPs	Use has likely increased considerably – need to get data	Price controlled so that dictates a lot of what is happening; interesting that this is an area where the private sector competes very well – because they are at parity with CRS CRS has 49% market share in 2017 per Nielsen	Healthiest of the categories based on competition in the market.

	Use & Market Size	Market Dynamics	Takeaways
ORS	Use not increasing	Also price controlled and there are other offerings Private sector reports staying out of the market because margins are not there due to government price controls	CRS does not appear to be crowding anyone out. But the price cap is crowding out potential entrants and there is reason to believe more products could thrive at different price points if regulations were changed.

Sources: NDHS, Nielsen data, CRS reports, interviews

Figure 4. Trends in use of selected modern contraceptives

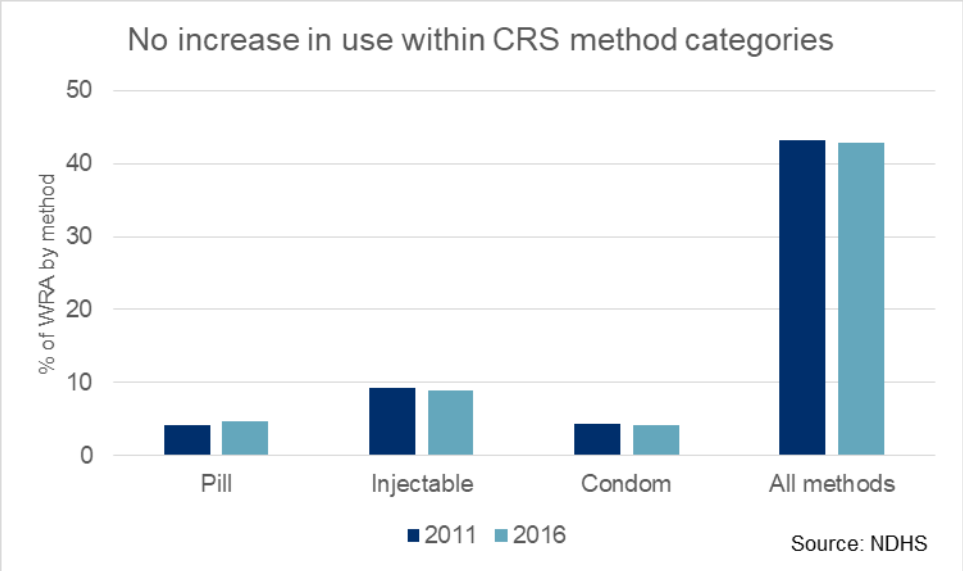
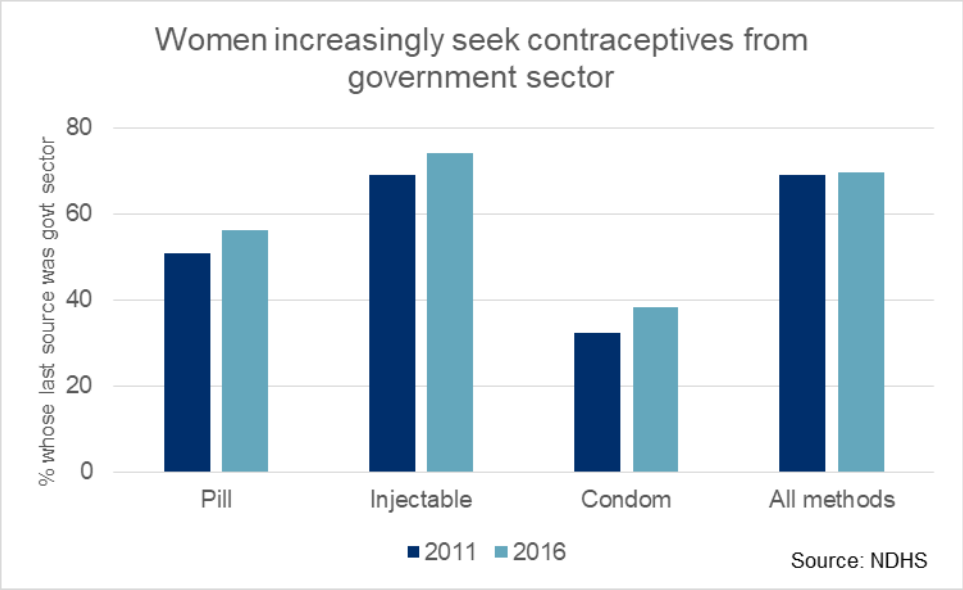


Figure 5. Trends in source of modern contraceptives



5. Opportunities for Developing the Private Health Sector in Nepal

This section explores the current state of private health sector (SHOPS Plus, 2018)[7] development in Nepal with a focus on health services. Findings build on two USAID-supported reports: USAID/Nepal Health Private Sector Landscape Assessment (PLSA) in 2017 and Sustainable Growth of Nepal's Family Planning Market through Improved Private Sector Engagement: A Political Economy Analysis in 2018.

The assessment focuses on four areas identified in the scope of work as critical for driving a larger contribution to health from the private sector: public private dialogue; regulation of the private sector; PPP; health financing; and TMA. The report also updates some of the findings from the previous reports, particularly regarding federalism, social health insurance, and PPPs.

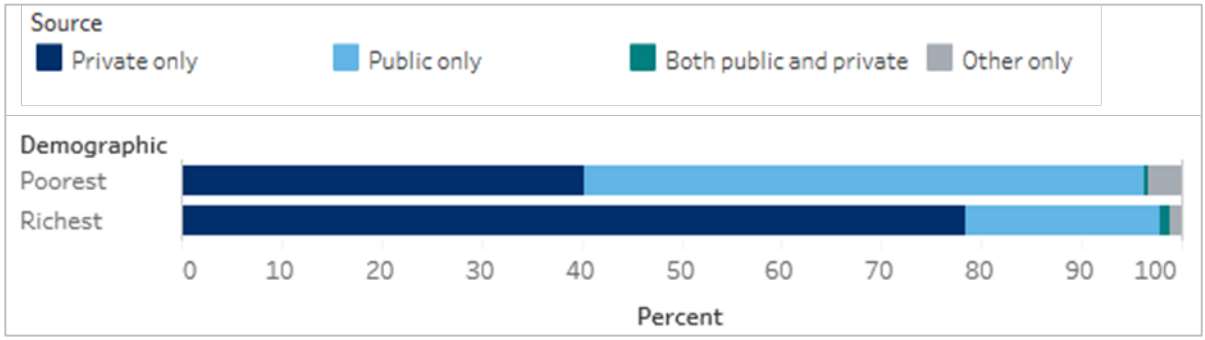
Why the Private Sector Matters in Nepal

The rationale for donor support of engagement and greater stewardship of the private health sector in Nepal includes:

- **The private health sector already plays an important role in health service provision in Nepal.** The NDHS 2016 shows that 72 percent of caregivers with a sick child seek care from private sector sources.
- **The private sector's role in FP is increasing.** The NDHS 2016 shows that the private sector provided 30 percent of all modern methods, up from 15 percent in NDHS 2000. The private sector's role is pivotal for some methods. In 2016, the private (non-state) sector supplied 61 percent of condoms and 44 percent of OCPs.
- **In Nepal, the private sector is used by both wealthy and poor populations.** Based on the NDHS 2016, poor and vulnerable populations that donors and the MOHP most want to reach seek care in the private health sector. For example, 40 percent of the poorest quintile and 78 percent of the wealthiest quintile seek care for their sick child in the private sector.

7 The Team found some confusion among stakeholders around private sector terminology. The report uses the following definitions. Private sector: According to the MOHP's draft Partnership Guidelines, "non-governmental or private institution" means any institution operated under the ownership and investment of a non-governmental or private sector entity as per the prevailing laws. This includes universities and academia owned by non-governmental or private sector organizations, cooperatives, or non-profit community organization. Public private engagement: Building the public sector's capacity to better steward the private sector while giving the private health sector a voice in health system decisions (SHOPS Plus, 2018). Partnership: The GoN defines partnership as any act of mutual understanding, collaboration or agreement among governmental and between governmental and private or non-governmental institutions to achieve specific objectives.

Figure 6. Comparison of richest and poorest wealth quintiles for care-seeking sources for children who have fever, diarrhea and/or ARI (2016)



Source: privatesectorcounts.org

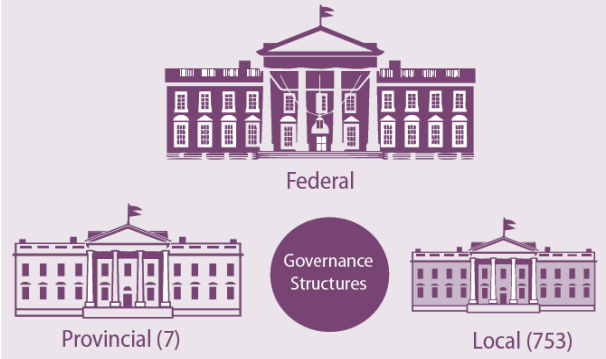
- **Progress toward universal health coverage can be accelerated by inclusion of the private sector.** Integrating the private health sector in Nepal's social health insurance ensures clients have access to a greater number of providers, including those they prefer.
- **Engaging with the private sector can help improve quality of health products and services in the private sector.** The PLSA found that private healthcare providers deliver the "best and worst" quality of care. Discussions with key stakeholders for this assessment confirmed this perception. A 2018 national survey of medicine shops and clinics by the Maternal and Child Survival Program found that just 10 percent of medicine shop providers and 32 percent of clinic physicians met the criteria for appropriate assessment of sick young infants (MCSP, 2018). Increased oversight and stewardship by the public sector can improve standards of care. Improved data collection from private facilities can help the MOHP better understand and manage challenges in the health system.

Photo credit: Save the Children
https://www.healthynewbornnetwork.org/hnn-content/uploads/MCSP-Nepal-PSBI-Survey-Brief.pdf

Background

In September 2015, Nepal became a federal democratic republic. The new Constitution ensures the right to free basic health services from the State. Three levels of government, federal, provincial and local, are replacing the traditional unitary system of government. This entails substantial devolution of powers to lower levels of government. The responsibility to deliver basic health services will be the sole responsibility of local governments, while the federal government will focus on policy-making, regulations, standards development, and monitoring (Nepal CCS, 2018-2022).

Many local governments have not yet developed processes and procedures for registration, accreditation, procurement, or contracting. Private sector actors, including CRS, are unclear how to engage with local authorities. In particular, there is significant confusion about which health commodities will be purchased locally and nationally.



Nepal Governance Structure under Federalism

Photo credit: http://nhssp.org.np/Resources/HPP/Health_policies_revisited.pdf

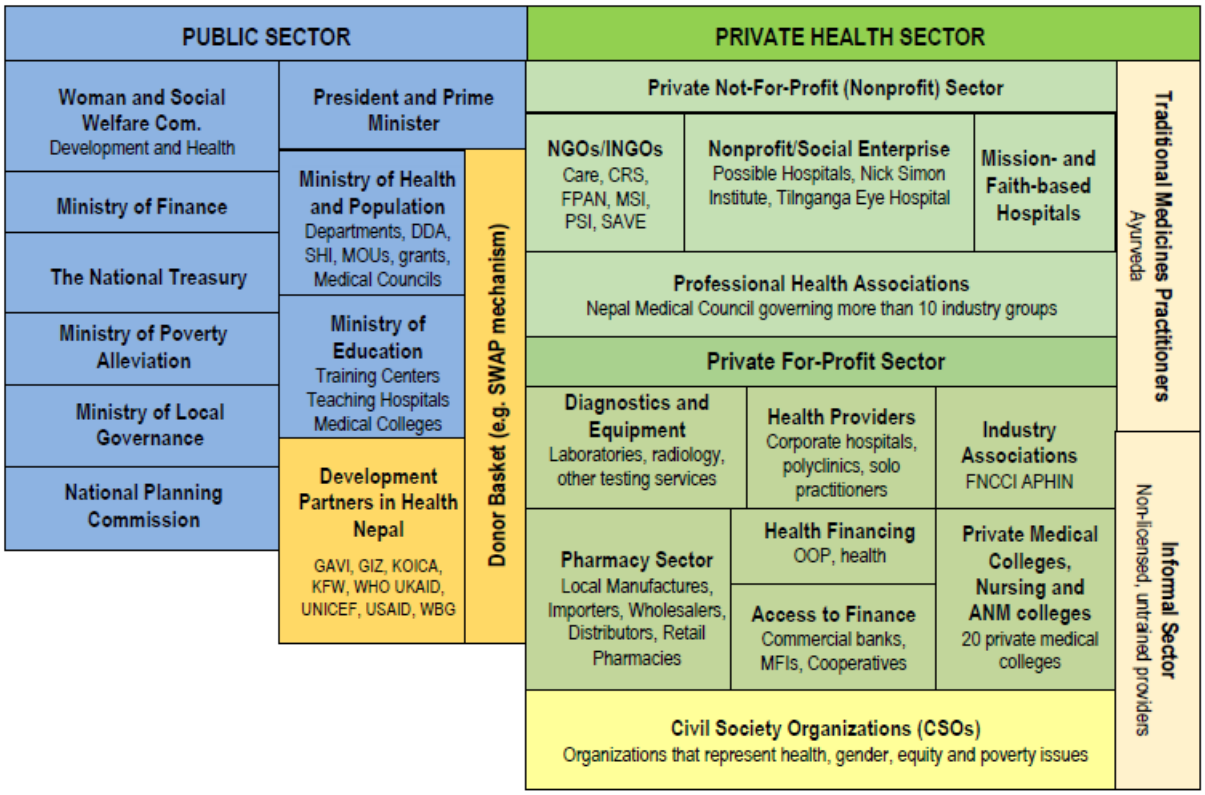
National and international NGOs interviewed for this assessment that have already reached out to local governments are finding that federalism presents many opportunities, particularly for contracting for service delivery. Stakeholders interviewed for this assessment had the following comments and/or concerns about the ongoing federalism reforms:

- Local government bodies have greater decision-making authority, but most local decision-makers are not public health specialists so health may take a back seat to other pressing issues.
- There are human resource and capacity issues at the provincial and municipal levels.
- There is a need for a decentralized warehouse system for essential medicines.
- Commodity security is at risk with federalism with a fear of commodity stock-outs as local governments, who may not be experts in supply chain, assume the role of purchaser for some health commodities. Family planning in particular may not be a priority for local governments.

Nepal Health Sector Landscape

As highlighted in the PLSA, there are many public and private sector actors involved in the provision of health services in Nepal (Figure 7). Key public sector stewards of the private sector include the MOHP, particularly the Family Welfare Division and District Public Health Offices, the DDA, and the Ministry of Local Governance. The private health sector comprises a large group of local and international NGOs and faith-based organizations, private for profit facilities, and traditional and informal medical practitioners.

Figure 7. Public and private sector health stakeholders in Nepal



Donors and International Organizations

Donors impact the private health sector through the sector-wide approach (SWAp) mechanism. The External Development Partners Group, which controls the SWAp donor basket of funds remains an important forum with Ministry of Health stakeholders. Currently, there are 12 formal signatories to the SWAp.[8] Table 8 shows donors active in the private sector with the projects they support. Actors that do not support private health sector activities, such as Gavi, UNICEF, Danish International Development Agency (DANIDA), Japan International Cooperation Agency (JICA) and the European Union (EU), are not included below.

[8] ibid

Table 8. Donors and international organizations with active private sector activities in Nepal

Organization	Activities with Private Sector Component
DFID and UKAID	Family Planning Project to address unmet need for FP in collaboration with UNFPA and international NGOs; Nepal Local Governance Support Program to improve governance at the local level and provide support for Health PPP Policy (UKAID, 2019)
KfW and GIZ	Support to CRS for feminine hygiene product pilot; Technical cooperation on health financing and social health insurance (BMZ, 2019)
WHO	Regulatory support to MOHP for registration and oversight of private health service providers; Multisectoral engagement and partnership for improved health outcomes (Republica, 2018)
World Bank Group	Nepal Health Sector Management Reform Program which increases government stewardship of health system (The World Bank, 2019)
UNFPA	Sexual and reproductive health services that target women and adolescent girls with international and local NGOs (United Nations Population Fund, 2017)
USAID	GGMS and SHOPS Plus (social marketing), SSBH (health systems strengthening), MCSP (maternal and child health services) (ended April 2019)

NGOs, Faith-Based Organizations, and Social Franchise Networks

Many international NGOs (INGO) serve as partners on donor-funded projects, including Save the Children, CARE, ADRA, PSI and MSI. Important local NGOs include Parapokar hospitals and fertility clinics, Netra Jyoti Sangh - an eye care NGO with 18 eye hospitals and 84 eye centers, and Nyaya Health with three municipal-level hospitals. There are also several missionary hospitals (Nepal CCS, 2018-2020). While some INGOs working in the health sector are funded by donors, others INGOs operate with their own financial resources, implementing programs under agreements with the Social Welfare Council. These programs are outside the purview and oversight of the MOHP (JAR, 2015).

Social franchising networks in Nepal include Family Planning Association of Nepal (FPAN), MSI, PSI, and CRS, which is technically a private social marketing company. Table 9 compares these networks by size, product or service focus, and funding source. Based on conversations with stakeholders for this assessment, most of the social franchising networks have a larger product offering and stronger quality oversight than CRS.

Table 9. Private provider networks in Nepal

Network	Number of Outlets or Providers	Focus	Funding
FPAN	2,750 service points, (127 static clinics, 116 mobile facilities, 184 associated clinics, 543 other agencies, and 2,000 community-based distributors/services)	Comprehensive counseling; family planning and sexual health services; safe abortion services; HIV and AIDS and other sexually-transmitted infection (STI) services; gynecological, prenatal, and post-natal care; and GBV care (Family Planning Association of Nepal, 2019)	International Planned Parenthood Federation
MSI	36 centers (MSI, 2019)	Family planning and safe abortion services	DFID
PSI	300 private providers	IUD, medical abortion	Anonymous donor, DFID
CRS Sangini	3,400 outlets	Injectable, short term methods	USAID, KfW

*While CRS is registered as a not-for-profit company, it is included here to compare with other private provider networks in Nepal.

Service Delivery

While statistics on the private health sector are difficult to come by, the MoHP website (GON MoHP, 2019) lists approximately 982 private health institutions in Kathmandu, including hospitals, clinics, polyclinics and medical centers as well as laboratories and dental offices. The Nepal Health Sector Strategy 2015 – 2020 notes the rapid growth of private hospitals from six in 1990 to 301 in 2014. The number of beds (19,580) in private hospitals far surpasses those in the public hospitals (5,644), with most in urban areas (GON, 2015-2020). The private health sector presence is uneven across the country, with the central region comprising over three-fourths of the total share. (RTI, 2010)

Private pharmacies and depots are another growing segment of the private health sector (GON, 2015-2020). The March 2019 Drug Bulletin of Nepal, published by the DDA, lists 21,651 registered pharmacies in Nepal, with 140 registered importers and 384 registered industries (GON DDA, 2019). While wholesalers and retailers of conventional medicine (allopathy) dominate, natural and homeopathic pharmacy outlets are also present in Nepal. The number of unauthorized pharmacies and drug shops in the country is unclear but could be sizeable. A

2018 Maternal and Child Survival Program survey of 400 medicine shops and 150 clinics found only 55 percent of participating drug shops were registered with the DDA. The proportion registered in peripheral and remote areas was much lower, at 36 percent and 34 percent respectively.[9] The March 2019 Drug Bulletin of Nepal lists 543 pharmaceutical industries in Nepal, with 336 foreign and 68 domestic allopathy facilities, and the rest veterinary and Ayurveda/herbal medicine producers.

Human Resources for Health and Private Health Training Institutions

Although no recent statistics are available, a 2013 assessment of health workers across the public and private sectors identified 54,177 health workers with 21,368 documented in the private health sector. Within the private sector, the largest group was the health management and support workers (45%) followed by nursing professionals (17%) and doctors (12%). Fewer paramedical practitioners worked in the private sector (1,160) than in the public sector (8,679). However, 80 percent of pharmacists, 75 percent of dentists and 60 percent of doctors worked in the private sector. Dual practice seems common. Of the 2,642 doctors employed in the private sector, approximately 60 worked less than 48 hours, indicating a likelihood they were also employed in the public sector.

Privately managed training institutions and medical schools have enjoyed significant growth since the opening of the sector to private investment in 1990.[10] There are 255 health education facilities listed on the Nepal Health Professional Council website, although it is unclear which are public and which are private (Nepal Professional Health Council, 2019). This is a 30 percent increase from a 2013 report on the role of the private sector in HRH in Nepal that identified 196 training institutions owned and run by the public and private sectors. The training institutions offered approximately 399 health related training courses, 19 percent of which were provided by government-owned institutions. Table 10 shows that a large number of the paramedical (178, 83%) and nurse (87, 67%) training courses were provided by private for-profit institutions and organizations. The private not-for-profit institutions offered only a few courses, mainly nursing and paramedical courses.

Table 10. Health training providers and types of courses, MOHP 2012

Provider Type	Public	Private-for-Profit	Private Not-for-Profit	Total
Medicine *	5	16	0	21
Dentistry	1	5	1	7
Pharmacy	4	22	1	27
Nursing and midwifery	37	87	5	129

[9] https://www.healthynewbornnetwork.org/hnn-content/uploads/MCSP-Nepal-PSBI-Survey-Brief.pdf
[10] http://www.nhssp.org.np/NHSSP_Archives/human_resources/HRH_Nepal_profile_august2013.pdf

Provider Type	Public	Private-for-Profit	Private Not-for-Profit	Total
Paramedical and other health workers	30	178	7	215
Total no.	77	308	14	399
Total %	19%	77%	4%	100%

The rapid privatization has made it difficult to control the quality of medical education and the subject of medical education has become highly politicized. Activists in Nepal have advocated for greater restrictions on private medical colleges, perceived as having poor quality controls and exorbitant tuition fees (Nambiar, 2019). The Professional Medical Education Act, commonly known as the Mathema Report, was prepared by the Mathema Commission, an independent body of educational experts in Nepal in 2014. Due to the delays in enacting the Professional Medical Education Act, Dr. Govinda KC, the leading medical education crusader in Nepal, has conducted over a dozen hunger strikes to pressure the Government of Nepal to implement this Act. In efforts to curtail growth of private training institutions, the National Assembly passed the draft National Medical Education Bill in January 2019. The highly contentious bill states that no letters of intent will be authorized for private medical, dental, or nursing colleges in Kathmandu Valley for the next 10 years. However, private educational institutions outside Kathmandu Valley are authorized on a case-by-case basis (Himalayan News Service, 2019) (Panthi, 2019). Activists feel the bill does not go far enough to control the growth of private medical colleges and feel the focus should be on improving health care services for the underprivileged.

Public-Private Dialogue

Public private dialogue underpins all successful efforts to improve government stewardship of the private sector and improve its quality. When public-private dialogue is working well, the private sector is included in ministry of health committees for strategy development and regulatory oversight, and is organized to advocate with unified private sector voice to the government.

Nepal has a long tradition of dialogue with non-state actors including external development partners and international NGOs. However, dialogue with local private sector actors is piecemeal at best. There are several public-private dialogue committees within the DDA and the MoHP. By and large, these forums are public-sector heavy, meet infrequently, have overlapping mandates and do not include the private for-profit health sector. Examples of existing government dialogue platforms include:

- Family Welfare Division: Reproductive Health Coordination Committee of the Department of Health Services with subcommittees on Adolescent Health, Safe Motherhood, and RH FP Logistics and services; and
- Non-Governmental Organization Coordination Council with 28 local and INGOs (semi-dormant).

Organizations Involved in PPE in Nepal

- National Medical Association
- National Nurses Association
- Midwives Society of Nepal
- National Pharmacy Association
- Nepal Chemist and Druggist Association
- APPON
- Private Hospital Association

Unlike many countries in Asia and Africa, Nepal has no private sector federation that serves an umbrella organization for all private health sector associations. There are only a few purely private sector organizations, such as the Association of Pharmaceutical Producers of Nepal (APPON) and the Private Hospital Association. In the absence of a private sector federation, several strong public-private organizations, including national associations of doctors, nurses, pharmacists, and midwives advocate for their constituencies. For example, the NMA and NNA successfully advocated to repeal portions of the 2018 Penal Code regarding medical negligence.

The Association of INGOs in Nepal (AIN) has a sub-group of agencies working on health that meets regularly to coordinate activities. However, there appears to be no formal interaction between the AIN health group, the MOHP, and donors. In general, INGOs are invited to policy and strategy forums but local NGOs and private for-profit stakeholders are excluded from public-private dialogue.

An effort to pilot a stronger collaborative relationship in managing health services between the MOHP and local governments in 2010, called the Local Health Governance Strengthening Program, had only limited success. District technical teams made up of district health office personnel, local development office personnel, TA representatives, and representatives of INGOs and NGOs were part of a partnership forum to identify local health priorities and promote health as a development agenda. It would be useful to understand why this pilot failed.

Regulation of the Private Health Sector

Regulation of the private health sector is essential to ensure the quality of private healthcare and medicine is acceptable and that abuse does not occur. In many countries in Asia and Africa, regulation of the private sector includes setting standards, conducting legislative reviews, and closely monitoring performance. In Nepal, regulation of the private sector is in transition, and names of ministries change with each new government.

Regulating pharmaceutical products and outlets

- The DDA regulates over 3,000 private pharmacies, but standards and safety of pharmaceutical products is a challenge, particularly with influx of illegal products from India and Nepal of questionable quality. New Drug Laws have been introduced to (restrictions on opening new pharmacies, higher qualifications for service provider, etc.). The DDA has no laboratory to monitor the quality of medical products like condoms.
- Key medicine policies and guidance include the Drug Act 1978, National Drug Policy 1995, Draft National Medicine Policy 2007, and the National List of Essential Medicines 2016 (MCSP, 2018).

The Ministry of Social Welfare has been repurposed as the Ministry of Women, Children, and Senior Citizens and focuses primarily on services and security for these groups. At the provincial level, the relatively new Ministry of Social Development (MOSD) oversees private hospitals. The MOSD has a Health Division that includes a Medical Service Division, Public Health Division, Drug Management Division, and an Ayurvedic & Alternative Medicine Division.

The Medical Service Division oversees private providers, although this new structure is not fully functional across the country. Private providers are also regulated through the Nepal Medical Council, Nepal Nurses Council, and National Health Professional Council for all health professionals besides doctors and nurses. While, in principal, all new health professionals must register with the councils, the councils have no follow-up mechanism and stakeholders interviewed for this assessment felt the lists were inaccurate. The Council lists include many registered professionals who have emigrated or died, despite a system of re-registration that has not been completely effective (Hemang, 2013). Several stakeholders indicated the private sector authorizations remain confusing and problematic. Currently, four separate entities oversee registration of private health facilities, depending on their size: a) Up to 15 beds register with the local government; b) 15-50 beds register with the provincial government; c) 50-200 beds register with DOHS; and d) 200+ beds register directly with MOHP Monitoring and Planning Division. With the anticipated enactment of the Public Health Policy and PPP Guidelines, the private sector's role will be clearer.

The DDA regulates pharmaceutical products and outlets. There is widespread concern that private drug shops are largely unauthorized, particularly in rural areas. The new Health Policy Act and tighter controls on unauthorized facilities are expected to be rolled out in the next few years. Some regulations have changed but they have not been consistently implemented. For example, pharmacists are not authorized to provide injections and must be affiliated with a nurse or doctor who provides injections either onsite or at a nearby facility. In reality, pharmacists and drug sellers may currently provide injections without penalty. Another example of a regulation that isn't consistently applied is the fact that paramedicals that receive a three-week training course can provide injectables.

Public Private Partnerships

Governments are increasingly turning to PPPs due to funding constraints and the importance of ongoing investment in infrastructure development. PPPs harness the efficiencies of the private sector to supplement limited public sector capacities. Nearby examples of successful PPPs in health include numerous partnerships in India to construct hospital facilities, diagnostic centers, and medical colleges. To properly motivate private sector investment in PPPs, India has developed a suite of guidance papers for PPPs in primary health facilities, hospitals, and diagnostic centers (The World Bank Group, 2019).

In Nepal, the National Planning Commission-(NPC) led the enactment of PPP Policy 2072 in 2015. The NPC highlights that in the federal system both the provincial and local governments can adopt and initiate PPPs to expedite development at local levels (GON NPC, 2018). It is important to note that health is not mentioned in the NPC's PPP policy. More recently, the GoN has focused on PPPs as a way to move Nepal to developing country status, including the following more recent partnership policies in health:

- The National Health Policy (NHP 2071) in 2014 with a specific policy element to promote PPP for systematic and qualitative development of health.
- The Nepal Health Sector Program 2015–2020 (NHSP-3), upholds PPP as a strategic direction (JAR, 2015).
- The draft State Non-State Partnership Policy (2012) emphasizes the need for improved partnerships between state and non-state actors and identifies strategies and operational plans that promote collaboration in Nepal's health sector.

- The Nepal Health Sector Strategy (2016-2021) embraces the concept of PPP and the importance of non-government health service providers in increasing people's access to health services in the country.
- The MOHP is developing new health partnership guidelines supported by USAID through SSBH.

There are strong partnership examples in providing services for eye health, family planning, and safe motherhood. Likewise, there is collaboration with some medical colleges in the production of human resources and provision of health services. However, such partnerships have been mostly one-off efforts and not based on a strategic and longer-term vision of strengthening the health system. Criticisms of the current ad hoc partnership efforts heard by the assessment team include:

- Partnerships are driven by specific programs and service delivery needs and without sufficient attention to performance and results.
- There are no clear guidelines to manage partnerships in the health sector.
- With federalism, the roles and responsibilities of the three spheres of government need to be better defined.
- Some partnerships were implemented without formal agreements and preference is given to insiders.

Health PPPs in Nepal

- Partnerships to deliver health services (e.g. eye care, management contract of Lamjung Community Hospital, Daeldhura Hospital, and Bayalpata Hospital)
- Partnerships to deliver maternity services (e.g. Aama)
- Partnerships with local bodies (e.g. Jiri District)
- Build, Own, Operate, Transfer (BOOT): Phaplu Hospital; Am Pipal Hospital; Manipal Medical College, and Bharatpur Medical College
- Build, Operate, Transfer (BOT): Lahan Eye Hospital, Trisuli Hospital, Western Regional Hospital
- Joint Venture: Nepal Eye Hospital

Source: PSLA, 2017

The GoN contracts with some for-profit hospitals and non-profits, including social marketing organizations and FP associations, particularly at the municipal level. The partnership process between the MOHP and the NGO Nyaya/Possible health is instructive. Nyaya started with a small unused public clinic in the Achham district in the Far West Region in 2008. Since there was no governing law for health PPPs, the PPP was negotiated on an ad hoc basis. Nyaya liaised with the Chief District Office, District Development Committee, other local government entities, and local community members. They also had to get approvals from the ministries of finance, justice, and home affairs. For the Achham district hospital, it took one year to sign the MOU granting Nyaya rights to the facility. That facility now provides health services to 350 patients per day. Possible opened its second hospital in Dolakha district in the aftermath of Nepal earthquakes 2015, again developing the PPP process as it went along. Nyaya recently signed a memorandum of understanding (MOU) with the federal government to deliver health services at the municipal level. For all of these PPPs, the MOHP is responsible for regulation/ standardization/quality assurance, and co-financing. Nyaya is responsible for co-financing and management of human resources. Nyaya receives support from vertical health programs such

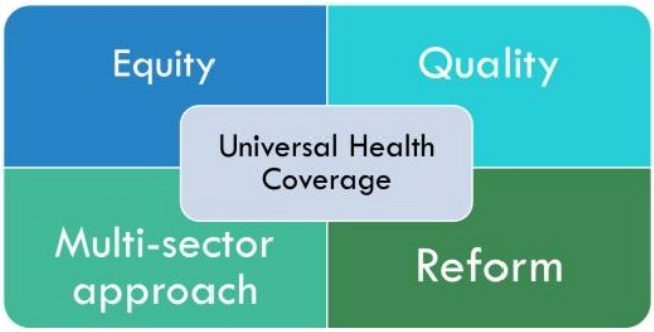
as the Safe Motherhood and HIV/AIDS programs, as well as in-kind support for drugs and supplies. Nyaya calculates its funding at 80 percent from family foundations in the United States and Hong Kong and 20 percent from the Government of Nepal. The MOU is renewed every five years for the first facility and every ten for the facility in Dolakha. Once the Partnership Guidelines are available, PPPs should be much more straightforward and more private sector stakeholders will be able to engage in partnerships.

Role of Private Sector in Social Health Insurance

In a country like Nepal where out of pocket expenditure as a share of current health expenditure is already 55 percent (World Data Atlas, 2019), social health insurance can protect beneficiaries from high, unexpected medical costs. Nepal has made impressive strides in social health insurance since it was launched on April 8, 2016. The Insurance Act of 2018 made the Health Insurance Board more autonomous and recent health insurance regulations have made the health insurance system more efficient. To date, there are 1.6 million insured, with an annual growth rate of 300,000 persons. There currently are over 135 non-state health institutions under the scheme, including NGOs, FBOs, private hospitals and foundations.

Private health facilities can become part of the social health insurance program. To date, however, most affiliated with the system are large multi-disciplinary hospitals. Beneficiaries choose a primary care facility. Depending on the availability of services in the public sector, they can request a referral letter to receive services in the private sector, provided that the private facility is already affiliated with the social health insurance board. To become part of the system, private health facilities require inspection by the insurance board and they must meet minimum quality standards. Once the private facility is approved to provide services, it can be reimbursed for services provided. While in principle it only takes 15 days for private providers to get reimbursed, it can take substantially longer.

Figure 8. Guiding Principles for UHC in Nepal



Source:http://nhssp.org.np/Resources/HPP/Stocktaking_the_Health_Policies_of_Nepal_April2018.pdf

Will a Total Market Approach (TMA) work in Nepal?

Efforts to meet unmet need for contraception are increasingly turning to a TMA to align implementers and funders around a common agenda. The "market" is more than the commercial sector: under a TMA it is defined more broadly to include all groups who play a part in the supply and demand for contraceptives as well as those who set the rules and regulations those groups must abide by. USAID refers to TMA as a "framework that helps stakeholders consider how best to use the full range of public, private, private commercial, nonprofit (including community- and faith-based), and donor resources in a country's health system to sustainably, equitably, and efficiently increase access to priority health information, products, and services." (USAID, 2016)

A TMA framework can be used to help segment the marketplace, identify which populations should receive subsidized and free health products, and ensure a role for the private sector over the long run.[11] Important elements of a TMA include stewardship, stakeholder engagement, market segmentation, targeted marketing strategies, service delivery and health financing strategies.

Since the Constitution of Nepal ensures free basic health services as a fundamental right, a logical question is the suitability of a market-based approach in the country. The assessment team found that public sector stakeholders did not have a high awareness of TMA, but they were aware of the need to try to maximize the contributions of different sectors.

Private sector stakeholders felt that the public sector was crowding out the private sector. They also expressed distrust of the public sector, particularly in honoring terms of contractual obligations and contract repayment. Manufacturers interviewed indicated they could be interested in producing more FP or MCH products, but only if the quantities were large enough and the restrictions on profit relaxed. The ability of free and subsidized products is a strong disincentive for new manufacturers to enter the FP and MCH markets, particularly when coupled with illegal product entry through India or China.

TMA was developed to address issues such as these.

Given this dynamic, a large TMA activity in Nepal might be challenging at the current time. Stakeholders felt that with federalism, the current Regional Health Coordination Committee at the central level would be a good forum for TMA discussions. While no such committee yet exists at the provincial level, such a committee would be logical for TMA efforts at the provincial level.

[11] ibid

6. Recommendations for Future Social Marketing and Private Sector Engagement Programs

There are a number of potential pathways – as well as partners in the non-profit and for-profit sectors in Nepal – that can contribute to public health goals through private sector engagement and application of social marketing skills. The following recommendations are intended to help unlock that potential.

Overarching Design Recommendations

Apply TMA principles. TMA provides a useful framework for organizing interventions aimed at satisfying unmet need for FP as well as increasing use of non-FP health products and services in maturing markets such as in Nepal. While there has been little dialogue around TMA in Nepal to date, adoption of TMA principles would address many challenges cited by stakeholders. TMA-inspired interventions would help the GoN to create a more enabling environment and bring together non-state actors in the NGO and commercial sectors to work collaboratively on supply and demand barriers facing multiple population segments.

Think more broadly about the role of social marketing. Social marketing of products and services at subsidized prices has played a critical role in increasing mCPR in Nepal and helped to build the total market for health products. In a maturing market, rather than continuing to focus on branded socially-marketed products and their average cost recovery, donors should consider the unique role that organizations with social marketing skills can play in changing consumer and provider behaviors – and generally in addressing supply-side and demand-side barriers to product uptake. While several of CRS's product-based interventions in Nepal can transition to an unsubsidized social enterprise model, continued social marketing interventions supported by donor and/or GoN funding implemented by a range of partners would help change behaviors, serve priority populations with lower ability to pay, and introduce new products to the market.

Specific Interventions

Enabling environment

- **Support GoN in developing a long-term vision for the contraceptive market** in collaboration with stakeholders from the commercial and NGO sectors. TA would be valuable in developing a vision to guide investment and orient the actions of stakeholders across sectors. Support to the private sector or NGOs under a TMA is compatible with the GoN vision of universal health coverage and guaranteeing each citizen a right to health care.
- **Invest in market stewardship capacity of the GoN** presumably within the MoHP. A technically strong and empowered stewardship team within the GoN is crucial to move the

vision forward and lead cross-sectoral collaboration. It could also play a key role in realizing the minimum standards for PPs circulated in draft policy frameworks (e.g., a dedicated organizational unit for partnerships, complete information on non-state health providers, a legal framework for the non-state sector and promotion of adherence to quality standards and accreditation). Donors could support TMA activities at the provincial and local levels via the District Health Coordination Committees. Support could initially focus on workshops to gain consensus and identify where different sectors overlap or crowd out one another. The next step is implementing a market segmentation exercise, followed by implementation of solutions to better segment the market and increase access to, and availability of, health products and services to all wealth quintiles.

- **Identify and support a market facilitator** to support the GoN in its stewardship role. Experiences from other countries beginning to work within a TMA suggest that longer-term TA, perhaps embedded in the GoN, would be valuable in maintaining momentum. Alternatively, organizations with a solid understanding of market dynamics who are not playing an active role in the market would be good candidates to provide support.
- **Invest in market research and dissemination to benefit all market actors**. There is a fair amount of research into, for example, barriers to contraceptive use. However, it is conducted piecemeal and is not always accessible to all market actors. When data is available, it is not always disseminated in a form that many different actors with different needs can benefit from. In particular, little project data tends to be shared with the private sector in many countries. Greater investment in this public good would potentially benefit stakeholders across sectors.
- **Support foundational steps to improve the organization of the private sector** including:
    - Support for the development of public-private dialogue platforms at the national and local levels that provide an opportunity to improve regulatory and service delivery bottlenecks and foster collaboration between the two sectors. SHOPS Plus has seen success with this approach in Ethiopia, Cote d'Ivoire, Senegal, and Madagascar.
    - Support for convenings of private sector stakeholders to identify common goals and determine whether a private sector association is necessary. If stakeholders feel a private sector association is needed, facilitate its development, including development of goals, mission statement, membership roster, legal status, board, and resource mobilization plan. A donor could also provide support to this fledgling organization through south-south exchanges and technical assistance.

Supply-side investments

- **CRS should consider transitioning to a social enterprise model for D'zire, Panther, Nilocon White and e-CON in urban and peri-urban areas**. These products are likely to be covering all of their costs and could likely serve urban and peri-urban markets without further subsidy. A key part of ensuring this transition would be allowing CRS to retain inventory and program income at the end of GGMS and lifting procurement restrictions for Nilocon White. This will reduce COGS and increase the cost recovery rate. The social enterprise model could eventually be a financially separate business unit within CRS (which is the model followed by SMC Bangladesh).
- **Narrowly target support for condom and OCP in harder-to-reach areas**. Continued subsidies for Dhaal and Sunaulo Gulaf would likely benefit many who could pay more. A more targeted approach to offering subsidized condoms and OCPs could be designed to meet the needs of population segments not reached through a social enterprise model. This support could include, or be complementary to, efforts to strengthen GoN systems that deliver free condoms and OCPs through the public sector. Performance-based contracts awarded by donors to NGOs or private companies could be used to incentivize opening and re-stocking of outlets in priority geographic areas. There are lessons learned from the Government of India's PPPs in this area.
- **Continue injectable supply through CRS in medium term**. Sangini serves a substantial number of women and no other private sector or NGO actor is currently well placed to make a contribution at scale. The long-term market vision developed by the GoN would consider evolution of this model to one that is less dependent on a single organization. Over the longer-term, a PPP to ensure supply from multiple entities, accompanied by a training and certification program, should be explored.
- **Consider support to apply social marketing approaches to an expanded range of products and behaviors**. Support could be provided to sanitary napkins, for example, if the CRS pilot proves successful. Consider nutritional products, which SMC markets for profit. Areas beyond traditional product-based work would likely benefit from social marketing expertise as well. For example, sanitation, cook stoves and fuels, tuberculosis case detection, and cessation of tobacco use are all areas where SMOs in other countries in the region collaborate with governments and donors.
- **Invest in service delivery networks**. There are a few service delivery networks in Nepal, including FPAN, MSI, PSI, and CRS's Sangini network. Each network, except for CRS, has relatively strong quality oversight. CRS is not able to adequately ensure the quality of all 3,400 Sangini outlets with current funding. To the extent that US government rules allow working with these organizations, investment would provide a platform for offering the full range of contraceptive products and services. Support could include the Sangini

network with a goal of increasing quality for a smaller, manageable number of service points given resource constraints. Lastly, network members have no collective voice in health decisions with the MoHP. Reactivating a dormant dialogue platform with MSI, PSI, and CRS participation, and adding FPAN, would help share lessons and coordinate activities.

- **Support GoN efforts at improving the quality of products and services through regulation**. SSBH plans to initiate several activities with the private health sector, including mapping of private health facilities in Province 5, a legal and regulatory review for the private sector, a private sector strategy, and development of partnership policy guidelines. These foundational activities are needed to better understand and plan for the development of the private health sector. However, additional support is needed to implement private sector activities at scale. The assessment team recommends the following support, in collaboration with WHO, which is also working on private sector registration:
    - The DDA and FWD could benefit from TA in finalizing and disseminating regulations to private health facilities. This is particularly important for provincial and municipal units that have not developed their own regulations and processes.
    - The pending SSBH census is an important first step in better understanding the scope and scale of the private health sector in Nepal. However, it is limited geographically to the RAI and clarity is needed about private providers operating in other areas of the country. A donor could invest in a system for enrolling qualified private providers and slowly develop a database of private providers. This would help push more private providers into the registration system/database.
    - The census could link technical assistance to non-authorized facilities to help them become authorized and improve their quality of care.
    - Once SSBH conducts a legal and regulatory review, donors could support workshops of public and private sector stakeholders to refine policies and protocols to make it easier for the private health sector to do business and provide quality services. In Senegal and Cote d'Ivoire, a legal and regulatory review served as a springboard to increased public-private dialogue and streamlining of onerous private sector regulations.
    - Donors can help with developing an autonomous accreditation body for quality assurance to ensure quality standards are developed, introduced, and employed across all public and private sector providers. This body could work closely with professional associations and regulatory authorities to ensure quality of health services and investigate non-compliance of service providers.
    - Donors can support simplifying DHIS2 reporting tools and disseminating these tools to increase private sector reporting. SHOPS Plus has conducted this exercise with

public and private sector stakeholders in several countries and the result is increased private sector reporting into DHIS2.

- **Promote greater private sector engagement by the public sector by supporting the following**:
    - There are currently too many overlapping and inactive committees at the DDA and the MOHP. It would be timely to identify the key health committees at each government agency and determine the stakeholders that need to be included, building on the Nepal Health Sector Support Program work, with UKAID support, listing the various committees and technical working groups of the health sector. Including the private for-profit sector in government committees is a priority.
    - The GoN needs to exercise better ownership and leadership over the many technical working groups in health.[1]
    - There are currently no provincial and municipal level dialogue platforms, so donors could support development of these public-private platforms and help develop a standardized membership list, duties, and roles.
    - The MOHP's focus on partnership presents an opportunity for donors to support development of PPP processes and assist with PPP training of government stakeholders at the provincial and local level. The ad hoc and exclusive nature of partnerships can be improved with dissemination of the pending Partnership Guidelines to for-profit and nonprofit private sector organizations.

Demand-side interventions

- **Invest more in BCC**. Multi-channel BCC and promotional campaigns for product categories, rather than specific brands, are public goods that benefit all sectors if interventions are well-funded enough to sustain a high-level of exposure for target audiences. BCC has proven effective in growing product use when initiatives are based on a strong understanding of the target audience and market dynamics so that investments in market research are complementary to BCC initiatives. There are a range of partners in Nepal capable of playing key roles, including CRS. Support would go to those best placed to serve specific populations and geographic areas.
- **Provide matching funds for importers and manufacturers looking to enter health product markets**. The N-MARC project experienced some success with engaging importers and manufacturers of health products through matching funds for product development and marketing as well as technical assistance. Further development of this model would help expand product availability and consumer choice while motivating all partners toward greater efficiency.

- **Support health financing strategies** to make private health services more accessible and serve as an incentive to improving quality standards. The evaluation team recommends:
    - Support to private providers through training on business and management skills, customer service, and how to apply for a bank loan.
    - TA to banks and microfinance institutions to encourage lending to the private health sector, such as through development of loan instruments tailored to the health sector.
    - TA to help private health facilities to obtain financing from equipment lenders.
    - Nepal's burgeoning social health insurance program presents significant opportunities for private providers in the country. Private providers need help connecting to the program while the social health insurance board needs TA to harmonize tariffs for private providers by region and standardize the MOU between the board and private providers.

Annex A. Assessment Scope of Work

Scope of Work

Assessment of Ghar Ghar Maa Swaasthya (GGMS) Project

Cooperative Agreement No. AID-367-A-10-00002

A. BACKGROUND

Since its inception as a project in 1976, CRS has been the key social marketing partner to the Ministry of Public Health (MoPH) and the leading supplier of family planning products in Nepal. Its contraceptive product range includes condoms, Oral Contraceptive Pills (OCPs), Injectable Contraception (ICs), Emergency Contraception (ECs), Intrauterine Devices (IUDs) and implants. In addition to these products, CRS social markets clean delivery kits, (Sexually Transmitted Infections) STI treatment kits, chlorine water treatment solution and Oral Rehydration Solution (ORS). CRS products and advertisements are present in all 77 districts of Nepal and its products reach more than 7,000 pharmacies throughout the country. CRS also has an extensive fractional franchise network of drug shops and clinics – branded as "Sangini" – in the 77 districts to support provision of ICs, and other products. CRS's status as a market leader in short acting Family Planning (FP) methods is underscored by its market share in condoms and OCPs – nearly 46 percent of all of Nepal's condom users use a CRS brand and 67 percent of Nepal's OCP users use a CRS brand. Similarly, as the main provider of injectable contraceptives through the private sector, CRS supplies its product to approximately 25 percent of injectable users in Nepal (NDHS 2016).

CRS has benefited from long-standing support from USAID, and more recently from KfW, especially for product purchases and distribution. CRS's social marketing and social franchising program has also benefited from local partnerships including the MoPH, the Nepal Chemists and Druggist Association (NCDA), and the Social Welfare Council.

In 2010, CRS received a cooperative agreement from USAID for the Ghar Ghar Maa Swaasthya (GGMS) Project, which was designed to leverage CRS' national capacity for promotion and distribution of health products, especially for family planning. Although national distribution was an expected activity, CRS was asked to focus distribution and promotion activities in 49 hill and mountain districts to better serve target groups with limited access to contraceptives. In 2015, after satisfactory performance by CRS, USAID decided to extend the GGMS agreement for an additional five years to continue to work on improving access and use of key health products, but with an additional focus on improving CRS' own institutional strength and independence.

While noting the substantial contributions of CRS to the health of Nepalese, an assessment of CRS by the Strengthening Health Outcomes through the Private Sector (SHOPS) project conducted in 2015 identified aspects which, if addressed, could enable CRS to achieve greater health impact, and operate more efficiently and sustainably. These areas include:

- Re-aligning CRS's sales, marketing and behavior change approaches to complement mass marketing with evidence-based, targeted strategies to change the behaviors of priority consumer segments;

- Increasing the availability of CRS products in remote and high-risk venues, including through innovative/entrepreneurial models;
- Improving the efficiency of CRS's operating platform by expanding its product suite, and by revising its pricing strategies in accordance with market conditions; and
- Strengthening internal organizational procedures and skills of CRS's staff to be able to respond to changing public health needs and opportunities.

B. GGMS PROJECT GOAL

USAID's GGMS project seeks to improve the health of disadvantaged populations in Nepal via improved accessibility and availability of health goods and services, especially in hard-to reach rural areas, through the use of social marketing and social franchising techniques. In doing so, GGMS supports the achievement of USAID's Country Development Cooperation Strategy (2014 – 2018) and its goal of "A More Democratic, Prosperous, and Resilient Nepal." By improving underprivileged and vulnerable populations' access and use of quality health services and products, GGMS contributes directly to the fulfilment of Development Objective 3: "Increased Human Capital" and its Intermediate Result (IR) 3.2: "A Healthier and Well-Nourished Population."

The specific purposes of the GGMS project are to:

- maximize the health impacts to Nepalese through the increased use of FP/RH, HIV and MCH commodities through the social marketing, social franchising and behavior change communications activities of CRS; and
- improve efficiency of the CRS organization as measured by cost per Couple Year of Protection (CYP) while still ensuring the successful achievement of GGMS program objectives.

C. GEOGRAPHIC COVERAGE

As a national social marketing program, CRS is currently working in all 75 districts of Nepal. For the purpose of the GGMS project, its target areas are defined differently depending on the activity as indicated below:

For product sales: All 75 districts of Nepal

For ensuring access to FP, HIV and MCH products: 49 districts of GGMS

For ensuring access to condoms in hot zones: 401 hot zones determined in the 2017 hotspot study

For ensuring quality of care: All Sangini providers in the 49 districts of GGMS

For improving knowledge attitudes and practices through SBCC and community mobilization activities:

The three Remote Areas Initiative (RAI) districts (Jumla, Bajang, Bardiya) and four Phase 2 RAI areas (Ramachhap, Terathum, Tanahun and Argakhanchi). Performance in the Phase 2 RAI areas will be assessed on the basis of improvement of knowledge, attitudes and use of critical health interventions.

D. KEY STRATEGIES AND ACTIVITIES

The CRS technical approach is aimed at increasing the coverage and efficiency of CRS's social marketing and social franchising activities in rural, hard-to-reach areas and in urban "hot" zones of Nepal. The primary strategies of the GGMS project are outlined below.

Strategy 1: Increasing demand for FP/RH, MCH and STI/HIV/AIDS prevention commodities and services through an evidence-based and consumer-oriented approach. This approach targets population segments with high risk/need via effective brand marketing and SBCC messages delivered through mass communications, public events, and interpersonal communications (IPC).

Strategy 2: Increasing and improving access to quality products and services in target areas and hot zones, including through innovative, entrepreneurial approaches and partnerships.

Strategy 3: Creating an efficient, cost effective social marketing platform that will provide donors with an attractive mechanism with which to fund incremental health outcomes.

Strategy 4: Strengthening the organizational policies and procedures, and skill sets of CRS staff to achieve GGMS project objectives.

The specific tactics and activities used by CRS in these strategies are detailed in project documents, workplans and reports.

E. SCOPE OF THE ASSESSMENT TEAM

This project assessment will cover the following areas:

1. The performance of CRS in implementing the GGMS project;
2. The impact of GGMS and CRS activities in the private health sector
3. Future opportunities for developing the private health sector in general and integrating social marketing in a private health sector strategy.

Specific assessment questions for each area are as follows:

1. <u>Performance of CRS in GGMS implementation</u>:
   - How well has CRS achieved the objectives set out for the GGMS project?
   - What progress has been made in improving access to health products?
   - What progress has been made in increasing knowledge, improving attitudes and increasing use of health products?
   - What progress has been made in making CRS a stronger, more sustainable and efficient organization?
   - What have been the major achievements of the GGMS project?
   - What were the major gaps or challenges in implementation?
   - What were (if any) the missed opportunities of CRS during implementation?
   - How well has CRS used best practices in social marketing and social franchising in the course of implementation?
   - How effectively has CRS made use of data and evidence in establishing and revising project strategies?

- How cost effective were CRS strategies and approaches?
- How well has CRS documented project achievements, successes, challenges and lessons learned?
- How well has CRS shared lessons learned and contributed to general knowledge of the community of implementing partners? What were CRS' partnerships or collaboration with other development organizations?
- How well did CRS collaborate with the government and support government strategies and priorities?
- How well did CRS work with its technical assistance partners (FHI360 and SHOPS Plus) during the project? Did CRS make the best use of the support offered by the technical assistance partner?

2. Impact of CRS and GGMS in the private health sector

- How have GGMS social marketing activities contributed to the expansion or the improvement in the quality of the private health sector in Nepal? Have GGMS activities helped to grow a sustainable commercial market for the provision of specific health products and services?
- What resources or contributions if any has CRS leveraged from the private health sector? Have media companies given the project concessionary rates? Have the distributors, wholesalers and retailers contributed time or resources?
- Have CRS/GGMS activities (advocacy, promotion, training, supervisions, etc.) contributed to improving the quality of products and/or services in the private health sector?
- Has the social marketing program had any negative impacts on the private health sector such as crowding out of commercial suppliers or discouraging investment in markets due to their dominant market position?
- Have any CRS/GGMS activities contributed to improving the organization of the private health sector? For example, has the project strengthened any private provider organizations or established new organizations or networks of private providers to help them improve practices or engage with the government?
- Have social marketing product subsidies been well targeted to consumer groups who most needed them?
- Are there some socially marketed products whose subsidies should be reduced or phased out to allow for greater commercial sector provision?

3. Opportunities for private health sector development:

- What can be done to improve the organization of the private health sector? Are there existing associations or organizations that can provide leadership and representation of private health providers that would benefit from institutional support?

- Are there private provider networks that can be strengthened and/or expanded through social franchising in order to improve quality, expand access and create an association of members capable of engaging the government in policy dialogue?
- What regulatory bodies need to do more to improve quality of products and services in Nepal? What investments or activities are needed to bring this about?
- How can the public sector promote more private sector engagement and dialogue between the sectors?
- Are there any existing health financing schemes in which the private health sector could participate to make private sector services more accessible?
- What opportunities are there for potential partnerships between commercial product or service suppliers and social marketing programs to build demand and make products or services more accessible?
- What opportunities exist to promote total market approaches for key health products and services? Which health products and services are most in need of better coordination and segmentation strategies to improve market efficiency and equity? Which entities (governmental or non-governmental) are best placed to lead TMAs? What role should the social marketing organization play in national TMAs?

F. PROFILE OF THE ASSESSMENT TEAM

The project assessment will require a team of three experts with the following profiles:

1. Social marketing expert: An expert in social marketing, social franchising and behavior change communications with broad knowledge of global best practices and previous experience with national social marketing organizations. At least five years direct experience in implementing product social marketing programs. Understanding of social marketing research and monitoring methods highly desirable. Fluent in written and spoken English

2. Private sector specialist: A private health sector expert with experience in analyzing private health systems and/or conducting policy and advocacy work around private health sector reforms. Familiarity with quality improvement/assurance systems for the private sector, private health sector financing techniques, public-private partnerships and private health sector engagement strategies. Fluent in written and spoken English.

3. Nepali Public Health Specialist: Nepali national with extensive experience in public health in Nepal and understanding of the health system and national health strategies and programs. Some experience of the private health sector and demonstrated understanding of the governance and regulatory environment for the private health sector, both for –profit and nonprofit sectors. Fluent in written and spoken Nepali. Highly proficient in written and spoken English.

Annex B. List of Documents Reviewed

Background Documents

1. Nepal Demographic and Health Surveys (NDHS 2006, 2011 and 2016)
2. USAID/Nepal Health Private Sector Landscape Analysis (PSLA), SSG Advisors (May 2017)
3. Sustainable Growth of Nepal's Family Planning Market: A political economy analysis, HP+ (September 2018)
4. Nepal Contraceptive Market Assessment (November 2015)
5. Evaluation of USAID/Nepal's Key Social Marketing and Franchising Project (N-MARC) (March 2010)
6. Ministry of Health and Population, Government of Nepal, Nepal Health Sector Strategy 2015 – 2020
7. Venkat Raman, "State Non-State Partnership Policy (SNP): Operational Strategies," (Kathmandu: Nepal Health Sector Support Programme, 2014).
8. USAID. A Total Market Approach to Family Planning Services. 2016.
9. Progress Report on Partnership, Alignment and Harmonisation in the Health Sector 2013/14, Report Prepared for Joint Annual Review (JAR), February 2015
10. RTI International, Ministry of Health and Population, Government of Nepal. Overview of public-private mix in health care service delivery in Nepal. North Carolina: RTI International; 2010.
11. Barnes, Jeffrey and Samantha Lint. 2018. Social Marketing Organizational Development Assessment Tool. Rockville, MD: Sustaining Health Outcomes through the Private Sector Plus Project, Abt Associates Inc.
12. Save the Children, Management of Sick Young Infants 0–2 Months of Age in the Private Sector in Nepal, MCSP, Sept. 2018
13. Nepal Health Sector Support Programme III. 2018. Report on Stocktaking the Health Policies of Nepal.
14. Nepal–WHO Country Cooperation Strategy (CCS), 2018–2022. New Delhi: World Health Organization, Regional Office for South-East Asia; 2018
15. Nielsen Market Share Reports (2017-2019)

Project Documents

1. GGMS Cooperative Agreement with Program Description (with modifications)
2. GGMS Annual Reports (2010-2018)
3. GGMS Performance Monitoring Plan (PMP) (Phase 1)
4. GGMS Monitoring Evaluation and Learning (MEL) Plan (Phase 2)
5. SHOPS Plus Annual Reports (2015-2018)

6. CRS Marketing Plans (selected from various products and years)
7. CRS Audit Reports (2015-2017)
8. CRS summary annual sales report (1978 to present)
9. CRS average cost recovery tables (2014 to present)
10. History of CRS (presentation)

Project Research Reports, Surveys, Assessments

1. ACNM Assessment of CRS Quality Assurance/Improvement Systems: Findings and Recommendations January 2017
2. Maternal and Child Health, Knowledge, Attitudes and Practices Survey in 49 Hill and Mountain Districts: A Comparative Analysis: 2011-2015 (FHI KAP)
3. Shiras, Tess, Sujan Karki, and Sarah E.K. Bradley. 2018. *Informing Reproductive and Child Health Social and Behavior Change Programs: Findings from a household survey in Nepal*. Rockville, MD: Sustaining Health Outcomes through the Private Sector Plus Project, Abt Associates Inc. (Phase 2 baseline)

Project Presentations and Other Unpublished Work

1. RAI Round 1 Final Report
2. Hot Zone Mapping Round 1
3. Assessment of private sector distribution strategy (presentation)
4. RAI Round 2 Baseline KAP
5. LQAS Results (presentation)
6. D'zire Reach and Recall Survey Results
7. Mystery Client Survey Report

Annex C. List of Stakeholders Interviewed

Name	Title	Affiliation
Ivana Lohar	Team Leader HIV, FP and Social Marketing	USAID
Sabita Tuladhar	Strategic Information and Research Officer	USAID
Nirupama Rai	AID Development Program Assistant	USAID
Gajendra Rai	Public Health Officer	USAID
Mahendra Shrestha	Chief Health Coordination Division	MoHP
Dipendra Raman Singh	Chief Quality Standard & Regulation Division	MoHP
Kunj Joshi	Director	MoHP (NHEICC)
Kabita Aryal	Chief Family Planning & RH Division	Family Welfare Division
Ramesh K Pokharel	Executive Director	Health Insurance Board
Pralhad Pant	Director Planning and Programme	Social Welfare Council
Jiblal Pokharel	Managing Director	CRS
Mahesh Dunghel	Deputy Managing Director	CRS
Rajesh Bhagat	Marketing Director	CRS
Amit Panday	Marketing Manager	CRS

Name	Title	Affiliation
Niraj Khanal	Field Operations Director	CRS
Neeti Sedhain	RM&E Director	CRS
Jyoti Shresthra	Acting Finance Director	CRS
Ajaya Risal	Senior Officer - Finance	CRS
Mona Sharma	Quality Assurance Manager	CRS
Ramesh Malla	Area Manager - Nepalgunj	CRS
Basanti Nepali (SP)	Field staff - Nepalgunj	CRS
Sunil Thapa	Field Officer - Nepalgunj	CRS
Binita Jaiswal	HR Director	CRS
Jeff Barnes	Technical Advisor	SHOPS Plus
Sujan Karki	Research Director	SHOPS Plus
Basanti Chaudhari	Former Community Change Agent	Bara Bardiya
Rekha Rain	Former Community Change Agent	Gulariya
Sita Rani Chaudhari	Former Community Change Agent	Madhuban
Rita Chaudhary	Former Community Change Agent	Rajapur
Samjhana Chaudhary	Former Community Change Agent	Rajapur
Ellen Pierce	Chief of Party	SSBH Project (USAID)
Neelima Shrestha	Private Sector Specialist	SSBH Project (USAID)

Name	Title	Affiliation
Deepak Paudel	Deputy Chief of Party	SSBH Project (USAID)
Dilli Raman Adhikari	Health Systems and Governance Specialist	SSBH Project (USAID)
Ishwar Nath Mishra	Program Manager, Health	ADRA Nepal
Deepak P Dahal	President	APPON
Heem S Shakya	Director Health Systems Strengthening	Chemonics Nepal
Deependra Pradhan	General Manager	CTL Pharmaceuticals
Narayan Dhakal	Director General	DDA
Deepak Karki	Health Adviser	DFID
Kedar Lal Shrestha	Marketing Manager	DJPL Pharmaceuticals
Subeda Farheen	Joint Treasurer	Fatima Foundation
Peter Oyloe	Former GGMS Technical Advisor	FHI 360
Bhagwan Shrestha	Project Director LINKAGES Nepal	FHI 360
Pangday Yonzone	Former GGMS AOR	Formerly USAID
Himalaya Kasajoo	President	FPAN
Chakra Raj Pandey	Chairman	Grande Hospital
Pooja Pandey Rana	Deputy Chief of Party, Program	HKI
Shanker Raj Pandey	Head Nepal Office	KfW Development Bank
Prajwal Jung Pandey	Director	Lomus Pharmaceuticals

Name	Title	Affiliation
Laxmi Tamang	President	MIDSON
K P Upadhyaya	Director	MSI
Mrigendra M Shrestha	President	NCDA
Pema Lakhi	Executive Director	NFCC
Muktiram Shrestha	President	NMA
Lochan Karki	General Secretary	NMA
Tara Pokharel	President	NNA
SP Kalauni	Executive Director	Nyaya Health Nepal
Tom How	Country Representative	PSI
Anjana KC Thapa	Project Manager, Saving Newborn Lives	Save the Children
Adhish Dhungana	Senior Health Program Manager	Save the Children
Joydeb Chakravarty	Managing Director	Thompson Agency
Shilpa Modi	Senior Digital Marketing Associate	Thompson Agency
Latika M Pradhan	Assistant Representative (RH)	UNFPA
Hem Raj Sharma	Managing Director	Unihealth Nepal
K B Rayamajhi	Former CRS Managing Director	Formerly CRS

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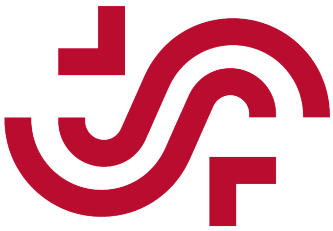

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